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ABSTRACT

Presented is the final report of the South End Project of the Boston University Head Start Evaluation and Research Center. In a Head Start community a setting was created to study and service preschool children with emotional and social disturbances from low income homes. During the 3-year project, 112 children were seen, families interviewed, referrals made, special programs developed, and follow-ups initiated. Attention was especially paid to the language used to describe disturbed behavior, the use of alternatives as educational-treatment devices to involve parents and community, the roles of professionals and other workers, and the use of behavioral variation as a conceptual vehicle for facilitating understanding of disturbance. Evidence was presented to support the argument that disturbance has to be studied in particular settings (either created or chosen), and that the findings will be a function of that setting. It is emphasized that, because lower income settings are particularly foreign to middle class researchers, they are very susceptible to bias, and that only after setting specific connections have been made and understood can generalization be possible. One is warned to be wary of generalizing a problem when it is simply a manifestation of a particular setting. (Author/KW)

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Special Education Department
School of Education
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DEVELOPMENT OF A SETTING AND AN ATTITUDE:
DISTURBANCE IN HEAD START

Final Report of the South End Project of the
Boston University Head Start Evaluation and Research Center

Frank Garfunkel
Principal Investigator

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ABSTRACT

A setting was created in a Head Start community in order to study and service preschool children with emotional and social disturbances from lower income homes. Over a three-year period, 112 children were seen, families interviewed, referrals made, special programs developed and follow-ups initiated. Particular attention was paid to the language used to describe disturbed behavior, the use of alternatives as educational-treatment devices to involve parents and community, the development of appropriate roles for professionals and individuals without formal training and the use of behavioral variation as an operational and conceptual vehicle for facilitating understanding of disturbance.

The argument was developed and evidence presented that disturbance has to be studied in particular settings which are either created or chosen, and findings will be very much a function of those settings. Only after setting specific connections have been made and understood will generalization be possible. Lower income settings will be particularly foreign to middle class researchers and therefore, unusually susceptible to bias. A problem can be viewed as being generalized, when it is simply a manifestation of a particular setting. Our particular concern in this clinical investigation was the dilemma of institutions -- to change individuals who do not fit or to change their structures and functions in order to fit the special needs and behaviors of individuals and groups. In lower income settings it is not always clear whether the individual has to be normalized or the institution transformed. The line between who is in and out of step is ambiguous and erratic. Our concern was with that illusive line and the people who were forever jumping over it, at least within our hazy perceptions.

Foreword

Clinical research necessarily involves many people who become involved not only with their work, but also with individuals and groups whom they service. Although one person takes responsibility for this report, it is important to acknowledge contributions of the following:

Mae Upperman - coordinator
Esther Walters - social worker
Pierre Johannet - psychiatry
Bertha Rogers - observer
Sherry Jones - teacher
Anne Keane Kruger - teacher
Dorothy Hahn - teacher
Halima Hamilton - neighborhood worker
Sarah Kidd - teacher

Other teachers, neighborhood workers, trainees, parents, too numerous to mention, played important roles. In particular, the personnel of the South End Family Service Clinic and its director, Don Taylor, were of invaluable assistance in getting our program underway, and then in picking it up after we left.

Mrs. Mary Schatz pulled together material from difficult sources and was always a careful critic.

Our biggest debt is to the South End families with whom we worked for almost three years. We hope they got as much out of us in service, as we received from them in understanding.

I. Introduction

Three years ago, the Boston University Head Start Evaluation and Research Center (BUER) embarked on a program both to service a community and to study mental health and emotional disturbances of preschool children through the local Head Start program. Originally, BUER staff included special educators, psychologists, educational research psychologists, social workers, and psychiatrists, all with an interest in and experience with young emotionally disturbed children. The staff shared an uneasiness with existing models of service and a commitment to the ideas that special services for disabled children should be an integral part of a total educational program, not an isolated appendage whose sole purpose is to treat sick children -- and that the operations of servicing and studying cannot be separated -- disturbed children cannot be studied without providing service; quality service requires research. From the outset, BUER rejected a medical model; First categorize types of sickness according to etiology, diagnosis, and prognosis, and then prescribe treatment to make the sick well. Instead, BUER opted for an educational model: First enumerate alternatives for children and parents which are realistic in light of social, economic, and political circumstances, and then facilitate the actualization of chosen alternatives.

BUER was also discontent with traditional experimental and survey research procedures. Instead, the staff chose participant observation as a means of studying the problem. Thus, research was combined with service; but neither facet of the program took priority over the other. Depending on who was to be impressed, BUER emphasized different facets of the program. In addressing itself to the community, BUER stressed ethical and pragmatic considerations. But to satisfy a research funding agency, the staff discussed research principles and problems. It emphasized the main problem in methodology: How do you study a problem that has not previously been attended to and for which there is no workable existing model?

The service-research model which evolved was BUER's answer to this question. The community's demand for maximal service and minimal study results from the current state of minimal service, which in turn, has led to a dearth of data. The claim of militants that blacks and lower-income individuals have been studied excessively is hardly credible as we have practically no research on education in the inner city, and longitudinal developmental studies of lower class children are virtually non-existent. But this claim has the effect of encouraging action research with a direct pay off to the community. Such research will not be hampered by the almost total absence of data and empirically grounded theory as much as a more formal research effort would be.

Survey, clinical and experimental studies and treatment programs of and for preschool children (ages 2-6) have focused on highly specific clinical subgroups (Rexford, 1949; Alpert 1955). The more generalized problem of prevention has received little attention, in spite of general acceptance of the assumption that disability is best prevented and treated when it is discovered as early as possible (Richmond & Lipton, 1961). Programmatic attention to early childhood disability is rare, with a few notable exceptions in retardation (Kirk, 1958; Blatt, 1968) but without exception in disturbance. Head Start, school system and state wide kindergarten programs do not include provisions for disabled children and, consequently, generally exclude them. It is ironic that children most in need of educational intervention are excluded, while those who are functioning at fairly high levels and have a less pressing need, are included.

The existence of free public kindergarten programs and their availability to children is a relatively recent phenomena in American education. However, kindergarten programs have developed in a highly selective manner. Wealthy suburban communities lead the way, and rural and lower income communities are the last to be effected. With few exceptions, there are no public school kindergarten programs in the Deep South (Kerkhoff, 1965) and, in most inner city areas, only a fraction of age eligible children are enrolled (Kerkhoff, 1965). Since school attendance is generally not compulsory until the age of seven, schools can and do exclude disabled children freely with the recommendation that they come back in a year or two.

In light of this situation it is not surprising that knowledge about disturbance of preschool children is highly specialized and, therefore, probably distorted. There has been a considerable amount of work done with middle class preschool psychotic children who happen to show behavior that is "interesting" to particular clinics or researchers. Each of these clinics freely excludes children that do not fit into their categories -- categories which are not only concerned with the child's behavior (autistic, atypical, anti-social, neurotic,) but with the parents' behavior as well (bring the child in twice a week, talk to a social worker once a week, keep appointments.)

This brief historical and current status survey is not meant to be a condemnation of what has been done -- these clinics have pioneered in service, training and research. But it is necessary to know where we are in order to plan research and service strategies and to extend our knowledge and service potential. Continuation of current treatment practices might serve to improve skills in dealing with highly restricted groups of middle class children, but it will neither extend our knowledge about behavior nor will it confront us with pervasive mental health problems of young children from all social classes. Similarly, the use of models derived from data which were obtained from special groups of children and methods are of dubious value in generalizing about incidence, diagnosis and treatment.

Albee's (1969) polemical critique of psychiatric clinics is manifest:

> . . . they are treating the wrong people; they are using the wrong methods; they are located in the wrong places; they are improperly-staffed and administered; and they require vast and widespread overhaul if they are to continue to exist as a viable institution. (p. 4)

While Schachter (1969) argues that much of what psychiatry has to offer is only for middle class consumers, the little data available make it clear that children and adults from lower social classes are practically untouched by any mental health resources (Ryan, 1969) including psychiatry. This is so as evidenced by state mental hospitals and state institutions for the retarded -- they are largely inhabited by individuals from lower social classes. It will be argued below that not only services and agencies, but roles and languages have emerged from training, practice, and theory, that are of dubious value for the study and treatment of disturbances of children from lower income homes, particularly of those who are members of ethnic and racial minorities.

In short, the success with which a problem is studied will depend partly on whether or not it has been effectively and operatively defined. If personnel and procedures for identifying and treating disabled children exist in a school system, then one can ask research questions about who the children are and how they are being treated, knowing full well that research methodology and results will be much effected by those personnel and procedures. If no such services or personnel exist, then the initial research questions revolve around the process of identification. If identification requires extended involvement -- observation, screening, follow-up, testing, referrel, questions -- it can only be done by personnel partially or wholly within the system. But if personnel and parents within the system have little feeling for and understanding of concepts of emotional disturbance which will help define the problem of identifying and treating disabled children, they will resist recognition of a problem and will balk at raising questions about existing services.

If concepts and categories were developed in a highly divergent setting, they will need considerable modification. They might be so tied to that setting as to lack even the possibility of generality. Procedures as well as tools must be modified accordingly. Referring a parent or teacher to a pediatrician, case worker or agency is an important part of the labeling-service process. A label connects a child to a service or a specialist. Whether the child does or does not fit the label often (or usually) becomes a primary question -- not what is, or is not wrong about the system and the child. While such a closed system has logical flaws and diagnostic disadvantages, it usually expedites the chances for services if a given child fits neatly into a category for which services are available. Even if the fit is forced by circumstances, the child's chances of receiving services are better than if there is no niche in which he can fit.

If, however, a set of labels bears little relation to available services, the closed system can result in labeling that minimizes the possibility of receiving services. Because no services may exist for certain disability groups, the label excludes the child from getting services through regular channels. For example, if a child is labeled mentally retarded, and classes are inadequate or nonexistent for the mentally retarded, then the label will, at the same time, prevent him from getting special services and from going into regular classes. What is at issue here is not simply a practical question of whether a given school system has certain kinds of services. A crucial theoretical-epistomological issue centers around the connection between language and action. Human behavior does not lend itself to absolute descriptive labeling. A child can not be labeled retarded or non-retarded depending merely on behavior he displays, and disregarding social-cultural context, peer behavior, and physical factors. Labeling must be relativistic and pragmatic. The question, "What good will it do?" takes precedence over, "Is it true?" When we can not address ourselves to the former question, we had better dispense with formal labeling and resort to the admittedly more inefficient open system of functional diagnosis. While this will leave many children without labels and their related services, it has the possibility of encouraging regular class integration.

II. Rationale

Language

The system of words and phrases used to describe children, their disabilities and treatment, is both an indication of the state of knowledge and a tool used by parents and professionals for identification, diagnosis and treatment. The implications of changing terminology -- insanity to mental illness to behavioral disturbance, feeble minded to mentally retarded, brain injured to learning disabled -- are important in understanding how education, treatment, and rehabilitation have developed in the last three decades. The claim is not that any simple connection between language, concepts, attitudes, and practices exists, but rather that attention to language can show the futility of applying an inadequate conceptual system to diverse educational situations.

The language of disability is based on a medical model of sickness, prescription, treatment, and cureability. Furthermore, the medical model presupposes the existence of a "doctor" and "hospital" where "illness" can be treated or, at least contained. It presupposes that most of the population is normal; that relatively few individuals need treatment except during a "plague," which is an extraordinary condition of limited duration in which conventional medical practice breaks down.

The operational gap between sickness and health in medicine sharply distinguishes it from education. The former focuses on the sick, and only incidently on the well (preventive medicine) while the latter deals with normality, and only peripherally with the disabled, (special education). But in special education, conceptual terminology is much more medically than educationally oriented. This state of affairs has been acceptable, (although not productive), as long as disabled children were relatively small in number and easy to isolate because of an apparent distributional gap between them and their normal peers. Middle class and inner city public schools may offer minimal or no special (segregated) services to emotionally, intellectually and perceptually marginal children while they exclude outright severly disabled children. The thousands of school age children in Boston who are not in school bear witness to this situation. (Brown 1970). The apparent distributional gap is an illusion given credence by looking at schools instead of children and by maintaining a terminology which purports to deal with varieties of child behavior, but really deals with highly selected samples of normal and abnormal children systematically excluding marginal children.

What happens to marginal children is of extreme importance to severely disturbed as well as to normal and high achieving children because it is so intimately related with the total educational scene. If schools are for all children and if disabled children are not a discrete group, then "special education" is a misnomer. The isolation incurred by using such terms as "mentally retarded" and "emotionally disturbed" can result in a large marginal group of children not being serviced. The problem, however, goes beyond the simpler question of who should receive services, but rather points to the more complex underlying question of the terminological-conceptual status of our language.

Maintaining the present system and service will serve to perpetuate a view of disability that excludes many more marginal children than it includes and that beclouds the extent to which disability is as much or more a function of the school than of the child. Studies indicate that mildly mentally retarded young adults with or without school identification become socially and economically indistinguishable from their non-retarded age peers after they leave school (Sarason, 1959); that no evidence exists for continuity of emotional disturbance from preschool to adulthood (Lewis, 1965); that provisions for materials and services for blind and partially sighted children counter indicate their being designated as educationally handicapped (Scholl, 1967). Moreover, evidence indicates that school failure of lower income children is much more related to inadequate home conditions than to tested achievement or intelligence (Fouracre, 1961, Kennedy, 1961); that the principal reasons for failure of mentally retarded individuals who leave institutions are social-emotional rather than intellectual (Gunzberg, 1958; Sarason, 1958); that incidence of disability is relatively high for school age children, and adolescents, but low for preschool (ages 0-5) and post school (ages 16 and up) individuals. All these findings point unequivocally in the same direction: Our language and services are part of an inappropriate model, one that encourages professionals and parents to use categories and develop services that do not fit empirical findings.

The misleading nature of the process of categorization is a problem to clinics as well as public schools. A child guidance clinic whose population is determined by a series of controls -- clinical, geographical, procedural--- does not lend itself to servicing or understanding a selected group of children. Similarly, populations of public school children are not representative because of many limiting factors, including school policies and procedures, and the kind of educational gerrymandering that has promoted homogeneity and prevents urban, suburban or rural schools from being exposed to anything like the total problem. Urban and poor rural schools legally and extra-legally exclude large numbers of children. They have to deal with relatively high prevalences of disturbance and retardation and large numbers of migrant children with extreme cultural (including language) differences. Rural communities have few services either within schools or without. Suburban schools, on the other hand, have relatively adundant services, but they tend to over identify learning disability and view behavior problems myopically because of socio-economic factors, including the availability of private facilities to supplement or take the place of public schools.

Both practical (services) and theoretical issues are affected by clinic organization. The connection between the scientific question of sampling, (Is it representative?), and the service question, (Is it adequate?) is directly analogous to the relation between the study of racial variation and racial integration. To study blacks in a racially segregated society will tell more about the society than about blacks. Clinical and educational studies of disturbances often reveal far more about schools and clinics than about disturbances and what to do about them. Our lack of understanding of disturbance is manifest when one looks closely at the language used to describe it. The extreme awkwardness of applying our value laden terminology to lower income children is an indication of its specificity and consequent limitations. For example, how does "mental retardation" apply to a public school where the mean I.Q. of the children is 80? How does emotional disturbance apply to a school district where most school age children do not finish school, where informal exclusion is a regular practice and where children are in the middle of a racial-economic-cultural bind?

The language of disability is awkward for main stream middle class children, too, but it succeeds in fitting many children to services and many facts to theories. It is not a systematic taxonomy for classifying disabled children to etiology, diagnosis, and prognosis. Terms and phrases currently used to label children with disabilities are a hodge podge which has grown out of sentimental and intellectual confusion. Medical terms have been freely appropriated to label psychological-educational behavior. Most terms refer to behavior which may or may not be relevant to education. Some are extremely specific referring only to certain behaviors; others are general and refer to a broad area of intellectual, social and emotional behaviors. Prognosis is often, but not necessarily implied. Symptoms are emphasized with little attention to how they developed or where they are leading. Endless polemic debates about whether determinants are genetic or environmental, and whether a condition is organic or functional (psychogenic) -- as if it has to be one or the other -- have only confused the issues.

A system of taxonomy that connected clusters of symptoms with etiology and consequences and that implied statements about the probable effects of certain kinds of treatments as opposed to other kinds or no treatment would be ideal; but no such system exists. What is known is that some teachers and therapists work well with some children, that the process appears to be working or at least surviving, not that there is a best way to teach disturbed or retarded children.

The criterion in the present taxonomy for classifying mentally retarded individuals is functional: Individuals are labeled mildly, moderately, severely, or profoundly retarded. The critical distinctions between children with greater or lesser potential for change because of the application of one or another educational approach are not made, nor is any explicit language adequate to make them. The same terminology applies to middle class children who are one tenth of one per cent of the child population and to lower class children who are twenty to forty per cent of the child population. The symptoms of mental retardation, as the designation is used in this country, are very much socio-economic class related, and yet the same labels are given to children without considering their radically different backgrounds.

Terminology in the field of emotional disturbance and social maladjustment is not as formalized as in retardation. Moreover, some qualitative distinctions have been made, for example, neurotic, psychotic, autistic, schizophrenic, atypical, character disorder, school phobic, withdrawn, acting out. Although many theories relate functioning to early experience, the empirical connection is largely unsubstantiated, and little evidence connects childhood disturbances with adult disturbances, either in the follow-up of disturbed children, or in retrospective studies of disturbed adults (Lewis, 1965).

The connection between labels and educational and therapeutic strategies is vague. Certainly, some adults (or classrooms) are better with some children, but the determination or which adult (or classroom) will be best for which child is, at best, educated guesswork. Predicting what will not work may be easier than what will work.

The claim here is not that observations of disturbed children are useless in educational and clinical work, but rather that we have no adequate, empirically based language to communicate about what is best for particular diagnostic groups of children, which severely limits the use of observations. We can discuss our observations and insights about particular children and situations, but we cannot assume transformation across children, teachers, or therapists. If educational models work it is because of the involvement of teachers, children and parents in their development and applications. But the appropriation of models by other teachers -- the export-import game of educational "innovation" -- is ineffective -- another indication of the inability or our language to describe critical components of behavior or structure. The fact that a child is retarded implies little or nothing about how he should be taught, by whom, where and for how long. All these decisions are made on the basis of other data about the child and his environment. In fact, the designation "retarded" could be eliminated without losing any vital clinical information. If a child does not talk or relate to other children or adults, do we gain anything by calling him austistic or retarded? Even if we do gain something, the chances are that less relevant information contained in the labels will be more influential (administratively) than more relevant description.

Furthermore, applying labels to children who display abnormal symptoms suggests that there is a unique approach which is needed to deal with these children, and that teachers need specialized training to gain a repertoire of knowledge and techniques. Whether or not special approaches are, in fact, needed depends on the quality and degree of differences that exist between children with and without disabilities, and whether these differences are educationally relevant. The large credability gap between the language of disability and educational and therapeutic practices associated with disabled children clouds questions about the need for special approaches. Moreover, discontinuity between labels and practices inhibits change in both and confuses the process of training specialists for work that is ill defined and, often, pointless.

Alternatives

Let us distinguish between educational programs that stress prescription and those that encourage agents at all levels -- children, parents, teachers, schools -- to choose from internally and externally generated alternatives. In the former, an agent is presented with a curriculum, a treatment plan, a workbook or a methodology; he has little or no effective choice (and should not have one) in deciding whether it is optimal for him and whether it should be used. This approach assumes that the given plan is at least as good as, or better than, any other plan, and that having an option is not consequential or not as consequential as having the given plan to follow -- as that being 'told what to do' is important in itself. If either condition is not satisfied, an educational model that maximizes possibilities for agent choices should be considered. When it is crucial for an agent to have external structure, to have the best possible plan, only then is a prescriptive educational program clearly justified.

Research on education and treatment of behavioral disturbances provides no evidence for the generalized superiority of any given method over others. This lack is due partly to the ambiguity in the definition of acceptable criteria for "superiority." But, more importantly, it is due to the trivial contribution that methodology makes to differential effects, as compared to other strong ingredients of educational process. The personalities -- and their interactions -- of the teacher, therapist, student, and client, and socio-cultural factors appear to weigh more heavily than given curricula, methodologies, or treatment plans. One can argue that approaches to education and treatment are not independent of personality and socio-cultural factors; that no education or treatment is without methodology; and that the methodology used bv a particular agent is an outgrowth of personality and culture. Clearly, the relationship between the student and teacher is a crucial factor in the selection of methodology, but this fact does not insure any direct relationship between method and effectiveness, Therefore, the claim that a single methodology, independent of particular agents, is superior to all others, is unlikely to be true.

The importance of options to the quality and degree of learning can be argued, but it does not readily lend itself to empirical verification. Prescriptive approaches are easily checked, one against the other, because sample assignment, instrumentation, teacher effects, and history can all be controlled. But the introduction of alternatives to various agents automatically contaminates a research design and makes it rather difficult to describe an independent variable for research purposes or for communication within various parts of the community. Nondescript programs may appear amorphous, and therefore inappropriate to research even if they are the most appropriate way of attending to educational needs. On the other hand, programs that have easily describable input can fulfill communication needs without focusing on needs of children. If, for example, problem selection is critical to problem solving, programs which exclusively focus on solving ready-made problems will not be relevant. If internally generated motivation is considered crucial to learning, the teacher or class that provides quantities of external motivation will not only avoid dealing with a basic problem, but may also make children excessively dependent on external sources.

The argument here is not that maximal use of alternatives in education and treatment is the best strategy, but that a program which makes use of alternatives may be legitimate under some conditions even though it lacks formal definition. Section two of this chapter describes experiences in dealing with preschool children with behavioral disturbances which suggest the need for such a strategy. The discontinuity between language, practices, theory, observed behaviors, and child groupings make prescriptive practices suspect. The impulse to delve directly into the validity of specified treatment approaches, is understandable, but premature. Developing a process that does not assume non-existent links (such as is the case in the study of discrete methods) and that increases the possibility that diverse courses of action can be scrutinized over a reasonable period of time, may be more enlightening in the long run.

The primary value of choice and agent initiative for change, rather than agent competence to follow through on assignments, is implicit in non-prescriptive programs. Parent involvement in discovering and selecting alternatives is given priority over the placement of children in specific therapeutic and educational situations. Of course, a program of providing alternatives and encouraging involvement is far easier to explain than to effect. The need for change can arise precisely because of uninvolvement, not due to lack of interest, but rather to lack of information and connections which lead to action. Involvement in choosing alternatives may be necessary for change. On the other hand, change can be effectively discouraged by providing specific services without giving options to agents.

Roles

BUER rapidly discovered that our training and experience did not equip us for the roles we began to play. In the beginning, we were occasionally called upon to do extraordinary things in order to have the clinic survive. Teachers recruiting for children, social workers in classrooms, psychiatrists lobbying cith hall and community people without formal training assuming professional roles became common. If we worked only with children brought to the clinic by parents, we would not survive. Accountability did not rest with credentials and affiliations, but with actions. The clinic had to succeed not only as a service and successful piece of research, but also in the minds and feelings of important sectors of the community. Everyone involved became a salesman -- a vital role which distinctly affected theory, practice and language.

When a researcher has to speak to community groups, visit parents, explain every step of the clinical-research process to skeptical individuals who have been trapped by the system he represents, he begins to see reliability, validity, and factorial designs in a different perspective. The psychiatrist who is on the community firing line, who cannot get parents to accept his aurhority or traditional practices, who had to spend hours, days and months in schools, is bound to view psychiatry and its traditional practice in a different light.

The new rules of our game became more important than old roles and traditions. Just as the old roles directed perceptions and confirmed their rationale, so did the new ones. But our old theories and practices had value only to the extent that they could be molded to deal with the new problems at hand. Our goals were never at issue -- only our means. But the processes of adaption to the community and accomodation of roles were not without their price. Traditional practices had to be abandoned in favor of unproved methods which were sometimes as difficult to use as they are to recall. A myriad of problems plagued every aspect of our relationship with children and families that were seen and not seen.

Many social workers, visiting nurses, and teachers are servicing the same families and children, but they are protected by fairly well defined roles and practices, by their organizations' continuity and functions, and by their professional community. Moreover, they do not have a research commitment to study the system, to ask questions continually about it and themselves. Without such protection, BUER staff was free to adjust roles and perceptions to reality, but they were also vulnerable to continaul remonstrances that they did not understand their roles or accomplishments. Who was responsible when tasks were not completed was not always clear. Planning was continually hampered because it appeared to involve arbitrary assignments and depended on individual understanding of what had to be done without professional or geographical guidelines to temper personal interactions.

Such a working situation combined with social, economic, educational and political conditions in an urban slum, bred repeated crises within the project staff and between staff and community. These crises had the potential of either destroying the project or producing a fertile situation for the better understanding and servicing of children and families with behavioral disorders.

The concurrence of innovation and turmoil in the clinical-research project in impoverished communities is no accident. To study and work with families that either have no choice, or have to chose the least noxious of undesirable alternatives calls for theory and methodology that are unrelated to those which generally appear in our scholarly journals. The most pressing social problems are untouched by traditional research procedures in the same way that education and treatment are not effected by conventional theory and practice. Research fails where it is most desperately needed unless a relationship between what is studied, how it is studied and by whom, is established. Not as an expedient, but as a theoretical imperative.

Understanding hunger -- as opposed to malnutrition -- is not accomplished by the study of nutrition, weight loss, or disease, but by closely observing people who are affected. Theories about social behavior will be influenced by the extent of involvement of observers. Intense involvement will produce an internal turmoil which will not lend itself to measurement reliability and behavioral designs. One may charge that such involvement leads to action rather than research. But this charge reflects a confusion between science and scientism -- between the appropriate study of behavior and the pretentious use of theories, methods, measurements, and analysis that wear a meaningful badge of authority, though they are completely imappropriate, if not inimical, to the problem at hand.

Behavior

The connection between our ideas -- about language, alternatives, and roles -- and the evaluation of the clinical research reported herein, revolves around a developing perspective about behavioral variations in children, particularly those with disturbances that seriously impair their social, emotional and intellectual functioning. We constantly conjecture about change -- expected and otherwise -- particularly if the children of note are severely disabled or disadvantaged. For most children the central issue of their upbringing is the way in which they will develop, not whether or not they will develop. It is not so much a question of whether they will go to school, but rather which school they will go to, what they will do when they get there, and what kinds of goals they will follow. On the other hand, the marginal individual is caught up in a struggle for survival. The need for a radical change in his environment and expected development is not a luxury or question of wishful thinking, it is a categorical imperative.

Let us first distinguish between development and change. That which is expected, whether it be retarded, normal or precocious, is referred to as developmental. It is just this that we cannot be satisfied with if our concern is with disability. We look for what might happen, either spontaneously or with some form of individual or environmental manipulation, that is not developmentally predictable -- in other words, as we use the word "change" we refer to altering a prediction about a child or a group. If a child is considered mentally retarded, then we want to know how to change the forecast that he will always be retarded. We want to know how to beat a system that is built on many personality theories that depend on stability and consistency for their validity. Intelligence depends on continuity or it does not make sense, at least in the way that it is currently used. I.Q.'s are not expected to change very much, which means, once removed, that the relative ordering of individuals on Binet, or other scores, does not change very much, which means that, twice removed, individual intelligence does not change very much. Or at least the conceptualization is rigged in that direction. Such predictability certainly makes it convenient for educational (and social) planning. If we know how people will be functioning in one, two, three or ten years -- emotionally, intellectually -- it is easier to design programs for the future.

So then, what is our theory for studying, diagnosing and treating emotional disturbances of children who exist within families which exist within communities? In light of what has already been said about current language, alternatives and roles, it should be clear that our emerging theory cannot accept traditional language, roles or strategies -- they go along with and derive from traditional predictions. Without eliminating all of the tools that have been developed, we can enter into a dialogue about the central focus of our observations: -- what and where are the optimal units for studying disturbance and disorganization -- individual children, nuclear families, extended families, communities, racial groups, inner city areas? How much context is needed before a symptom becomes an understandable and specific part of a strategy for change? How do we distinguish between relevant and irrelevant information without becoming inundated by data? And perhaps most critically, for whom are the theories being developed? Our work has led to a series of operational principles which are a cross between theory and methodology. At the present time these principles are all the theory that is available to us -- they provide guidelines for action and are closely tied to value judgements that are very much a part of the process. Principles connected with language, alternatives and roles have already been discussed. Central to these three issues is the specificity of behavior -- the contingencies and conditions for variation. Under what conditions will a child's behavior change or remain constant? We see this as the crucial operational question to be pondered by schools, clinics, parents and anyone who is devoutly interested and involved in change.

We conceptualize a continuum of behavioral specificities that vary between child and situation. Child specific refers to behaviors of a child that do not vary over situation. It is that which remains relatively constant in diverse situations, with different people and at different times. Situation specific are those behaviors that vary from situation to situation, person to person and time to time. They suggest behaviors that adapt to the changing characteristics of situations and people.

Neither child nor situation specificity is meant to represent an absolute -- no behaviors would be completely child or situation specific. However, the continuum can be of critical importance to the development of a program where changes in individuals and environments are questions of survival. The question, "How can a child be influenced, directed or forced to change?," must be preceeded by the knowledge of how that child's behavior varies. Does his behavior vary with different adults or children? Does he behave differently at school than at home? Does he function differently under threat than under support?

It is our assumption that change does not come from either a vacuum or supernatural forces, but rather from existing behaviors. Change involves redirection, substitution, modification and intensification on existing behavioral variations. Clinicians and educators have to explore the surface and depths of existing variations in order to enter into a process which will not be so defeating. We know, for example, that I.Q. as derived from the Stanford-Binet, is relatively invariant to examiner, conditions of testing, type of reinforcement used, and age when test is given. The I.Q. has been systematically rigged so that it is basically child specific data. This is, at the same time, a great strength and a great weakness. If you are interested in situational variations, using the Stanford-Binet as a criterion will insure negative results.

To carry this a step further than the Stanford-Binet, putting a priority on change means shelving those aspects of language, role and strategy that counter indicate variability, even if it forces teachers and clinicians to lose ground in the struggle for identity. More specifically, it calls for programmatic innovation for the purpose of revealing variability. We are burdened with well established practices and institutions that prevent variability from being seen. The structures of schools and clinics are clear cases in point: Homogeneous behaviors of staff and children are clearly encouraged, heterogenous behaviors are usually attributed to situations and teachers rather than to the diverse behavioral possibilities of children or adolescents. Many clinics are satisfied to see children and their parents always within the clinic walls. Many psychiatrists never observe children with whom they are working at home, in school or in play outside of any formal setting. Teachers will readily admit that learning is not confined to the school facility, but rarely do they (or are they encouraged to) seek opportunities to observe their pupil in diverse out-of-school and other in-school situations. Children who are diagnosed as being mentally retarded, but who later function normally, are often said to be cases of psuedo-retardation -- that the diagnostician made a mistake, in preference to an explanation which depends upon the child having changed. This is simply a manifestation of a very strong and pervasive prejudice (among others). A belief in change (as opposed to development) of pupils or clients has direct implications for a practitioner's self-awareness, values, and satisfaction with life. While it is easy to agree about the need for changes in many clients and their families, it is more difficult for this change to be theoretically and functionally connected to changes on society and self. This has to be a direct threat to the middle class practitioner, unless he is able to effectively partition his life apart from the lives of the poor and disabled. But this fragmentation is just what has to be broken down if there is to be a disposition for change. There are ways in which people think and feel that will tend to open or close working models. This becomes a question of competence when the education or treatment is to be evaluated in terms of openness -- a condition that is characteristic of poverty.

Our thoughts about language, roles and alternatives are the result of working in communities, observing and being observed. This work led to questions about what educators, social workers, psychologists and psychiatrists have to offer. Our immediate response was very negative -- the situation in and around the South End Head Start program desperately needed something -- but it was not our polished group of professionals. But the unpolished non-professionals were not doing the job either. Professionalism certainly has its hang-ups and can be eloquently inappropriate for dealing with educational and mental health problems in impoverished areas. But the alternative of not having any professionals involved can very well lead to a political system devoid of educational goals. In the South End there were many things going on -- but they did not include education, at least for the children. Behavior homogeniety was being systematically built into this institutional wall. This was just as true for "good little boys and girls" as for the "bad ones."

Because of our previous interest, a mandate from the division of Research and Evaluation of Project Head Start, and some community interest, we began to organize a clinic. It was this organization with its resulting struggles to define the population, talk to teachers, work with parents and be involved with children, that led us to at least begin to speak a different language, assume different roles and work with parents towards their assumption of responsibility for making choices and following through on these choices.

This led to clinical strategies for provoking action -- getting agencies to move, parents to demand and the community to become more aware. The most significant aspect of these evolving strategies was our growing awareness of a theoretical position which connected contemporaneous to longitudinal variation. Our description of this theory is tentative -- it borrows heavily from field theory (Lewin). The problem is that such theory must include change agents. Too much action theory does not consider the values and abilities and personalties of change agents who are probably more important than any theory about structure that is applied to a situation. This calls for comprehensive theory that covers agents, objects and process. We have to begin to talk about changes in agents that will have to accompany changes in objects, and strategies that are limited to selected agents. We are probably going to have to do a lot more thinking about the values, politics and professional points of view of agents, so that they can be part of such a theory.

This monograph scratches the surface by describing the development of operations of the Clinic and then by presenting data on the sample of children seen, including case material about individual children and families. Altogether, the Clinic, the sample and the procedures have contributed to the development of a setting where problems can be studied and where both agents and clients can change and, to a certain extent, become interchangeable.

III. The Creation of a Setting

Procedures

To discover ways of treating and studying emotional disturbance in lower income communities, BUER developed a psycho-educational clinic in Boston's South End. Primary strategies were to provide educational alternatives for parents and children and involve the community in decisions about educational programs.

The South End is a study in contrasts: Juxtaposed with decaying tenaments are housing projects; different racial and ethnic groups are scattered throughout the community; prostitution and narcotics abound in the shadows of social agencies, churches, hospitals and public schools; residential areas are mingled with commercial centers; slum blocks are interspersed with expensive renovated brownstones with clean yards and newly planted trees. But despite its variety, the South End is a distinct community trying to solve its many problems.

The South End is one of eleven Boston Areas which receive funds through Action for Boston Community Development (ABCD) from federal poverty programs. The South End Neighborhood Action Program (SNAP) is the area planning action council (APAC) which has a full-time paid executive director and an elected board. SNAP administers the Head Start Program in the South End and was, therefore, the principal community agency with which BUER collaborated.

BUER's diagnostic program can be divided into five phases. The first phase, summer of 1967, was concerned with initiating a program to screen South End Head Start children in order to identify those with social-emotional or educational problems. Screening was performed by a multi-disciplinary group coordinated by BUER and composed of faculty and students from the Department of Special Education and Psychiatry, Boston University. The second stage, the 1967-1968 year-round program, was based in the community and staffed by a small diagnostic team from BUER and SNAP. The year-round program was less formal than the summer program and served as a consultant resource for Head Start teachers and parents. Phase three, summer of 1968, was, again, a large scale operation in the community in collaboration with SNAP. The year-round 1968-1969 stage was characterized by flexibility, informality, and improving relations with SNAP and the community. The final stage, summer of 1969, was the culmination of the collaboration between BUER and SNAP. A review of procedures and achievements of BUER's Clinic during each of these phases will follow.

Summer of 1967

During the summer of 1967, BUER was concerned mainly with informing the community about the Clinic, finding children with educational problems, screening them, and discovering and creating resources within the community which were or could be educational alternatives for disturbed children. To educate the community about diagnostic service, BUER met with SNAP to discuss the purpose of the program. SNAP neighborhood workers and Head Start teachers and trainees were informed as to when, where, and how they could seek either direct help for emotionally disturbed children or consultations. Neighborhood workers were enlisted to inform families about the services of the Clinic. Moreover, they were asked to act as liaisons between BUER and families and to conduct family interviews.

Teachers and trainees were requested to refer, as soon as possible, children about whom they had questions. The kinds of behavior that would be of interest to BUER were discussed, and teachers were encouraged to ask members of the clinic team to make observations of any child regardless of the problem. Procedures for initiating observation and for filling out basic information forms were also discussed.

Children with problems were referred during the 1967 summer by teachers and trainees, or observers from BUER who visited classrooms regularly. At first, teachers expressed reluctance to refer children having problems adjusting to classrooms. They were concerned about unnecessarily labeling children as disturbed or retarded. Moreover, they had reservations about discussing a child's problems with his parents. The teachers' reluctance was traced to a lack of confidence in their ability to handle children with severe problems. In addition, it revealed a fear that they would be blamed by parents for a child's problems and that repercussions would occur. To allay teachers' fears, BUER and SNAP staff shared the responsibility of discussing a child's problems with his parents when the need for extensive treatment was indicated. But even so, some children were brought to diagnostics without their parents' consent.

Parents were not always told even of serious problems that needed immediate attention. During the summer session, procedures which evolved for dealing with parents of disturbed children met with varying degrees of success.

Occasionally, referrals resulted from discussions between observers and teachers. Generally, these referrals were informal in nature and did not require a total work-up on a child. Informal referrals gave teachers occasion to discuss a variety of children with consultants and to ask questions that could be answered on the spot. Frequently, the children discussed during these informal meetings were troubling teachers for more subtle reasons than those children who were more clearly identified as being maladjusted. Often, a child's problem was not intrinsic, but rather stemmed from the classroom situation. Informal referrals served to attune teachers, observers, and consultants to such problems in the educational process.

If the need for formal diagnostic work-up was indicated, BUER began classroom observations, family interviews, administration of various tests, and diagnostic nursery sessions. The classroom observation was written by the child's teacher and an educational consultant, and included a description of the classroom facility, teacher style, classroom atmosphere, and any other significant feature of the class. Information concerning the child's behavior in class and the teacher's opinion as to the severity of the child's problem was gathered. After formal diagnostic procedures were completed and recommendations made, classroom observations were repeated to check on the feasibility of the recommendations and to advise teachers on how to implement changes. Some teachers consulted regularly with observers, discussing various children and techniques. Other teachers were more reluctant to enter into a dialogue.

To throw light on the extent to which a child's home life was affecting his behavior, SNAP staff in conjunction with BUER, conducted family interviews. Family interviewers were community members hired by SNAP to offer social service assistance to their neighbors. As community members, they had no trouble entering the home and obtaining information, while BUER professionals in the same role encountered resentment. But, at the same time, the neighborhood workers were not trained interviewers nor were they trained in developmental psychology or early childhood education. They did not understand the relevance of some of the information they were asked to obtain, and, as a result, they were sometimes unwilling to complete the whole interview.

In addition to family interviews and classroom observations, Stanford-Binet tests were administered to obtain an idea of a child's capabilities. The psychologist administered the test using standardized procedures, and then revisited the child to repeat items the child had failed. The repetition of failed items gave insight into the child's learning patterns and served as research data concerning learning. The data from the Stanford-Binet and other tests -- both formal and informal -- were discussed at staff meetings. SNAP staff were present at these meetings though they were not given scores of the tests nor were they given in-depth training about the instruments.

To facilitate intensive study of disturbed children, BUER held diagnostic nursery sessions. Each child referred attended sessions for three successive days along with three to five other children who had also been referred. These sessions were very flexible and staff were free to change their content and structure during and between sessions depending on responses of children.

Teachers and trainees observed these diagnostic sessions, but rarely participated actively. Once, however, a teacher darted out of the observation room and told the diagnostic teachers how to handle the children. Her behavior was clinically scrutinized by BUER staff. It illustrated the situational aspect of the problems of the children she had referred. One child, she believed, was a behavioral problem because he refused to separate from his sister. He was unnaturally fearful, she claimed. As an example of an extreme demonstration of fright, she cited an incident during which he had fallen into the alligator pit at the Children's Zoo. Despite the fact that only baby alligators were in the pit and that the nearest one was at least five feet away, the child, according to the teacher, was abnormally terrified. This same child, she added, had an unnatural fear of being left behind. He continually ran ahead of the group on class trips and, as a result, got lost one day. This teacher referred another child because of his passiveness and solitary play. To counteract this behavior, she entered into dramatic play with him encouraging him to hit and kick out at her. He was instructed to make all the sounds and gestures of physical aggression, and she in turn responded with sounds appropriate to someone being hurt.

The teacher's vivid descriptions of her interactions with children she had referred and her behavior during the diagnostic session demonstrated clearly that many of the children's problems stemmed directly from her relationship with them and thus were not intrinsic to them.

The diagnostic nursery sessions then, were sometimes invaluable in diagnosing a child's disturbance or its immediate source. The teaching staff, however, argued that they were unrealistic. They insisted that the isolated setting and small groups were unnatural, and suggested that demonstrations in their own poorly equipped crowded classrooms were more relevant to their needs.

After observations and testing of a child were completed, BUER and SNAP staff met to discuss the information gained and draw conclusions. Teachers participated by giving additional information and discussing the feasibility of various possible courses of action. Recommendations were compiled by the diagnostic staff and discussed with the classroom staff. Most recommendations were educational in nature. They indicated new techniques of dealing with a child in the classroom as well as alternatives for school placement for the following year. Frequently, the diagnostic team revisited the class after such recommendations to demonstrate specific techniques and to discuss class processes at the request of the teaching staff. Often recommendations involved several children in a class and required a set of new tactics for handling groups of children. When a child's problem was situational rather than intrinsic, and when comprehensive recommendations as to methods of dealing with it were made, teachers were more inclined to confront parents with their child's problem. Many teachers had already reported severely disturbed children to parents. When teachers could offer concrete recommendations to parents, when they could suggest some course of action, they were much less reluctant to approach parents. Most teachers found this stage of interaction with parents much easier than the initial contact.

The most common educational recommendations, beyond those which could be implemented during the summer, were for retaining children in year-round Head Start classes or for placement in the Head Start special class for severely disturbed children where they could be observed and more directly dealt with. Recommendations, however, were not always of an educational nature; health care and social services were suggested for some children. Neighborhood workers carried out these recommendations and reported to BUER if action was initiated.

As was expected, the summer of 1967 phase of BUER's diagnostic program was beset with difficulties. First of all, the program suffered all the setbacks characteristic of federal poverty programs. Funds were granted late; staff was hired late; people were rushed into jobs and then expected to operate efficiently immediately. Moreover, the Head Start program was being reorganized under the jurisdiction of SNAP. Setting up a program without precedent to guide organization is difficult enough in a stable atmosphere. BUER was trying to collaborate with teachers and neighborhood workers new to their jobs and unfamiliar with their roles in another new and undefined program. Throughout the summer, BUER came to recognize the differences in values and skills which hampered the BUER-SNAP collaboration. Moreover, staff began to discover the problems involved in working with parents in a lower income community. The summer of 1967 was valuable, for it brought to light the need for new techniques of dealing with teachers and the community. In addition, it served to test the diagnostic procedures of the clinic. Refinement and revision of techniques were begun in the fall.

Year-Round 1967-1968 Phase

The 1967-1968 phase was concerned with the continuation of diagnostic services and the establishment and support of two new Head Start classes, one of which was for demonstration purposes and the other for children whose developmental problems were such as to prohibit their participation in regular Head Start classes. In addition to these concerns, BUER intensified its efforts to work directly with parents and community agencies and include them in the process of planning diagnostic services.

The diagnostic services and year-round Head Start program began almost simultaneously. Orientation for teachers and neighborhood workers began a week before the scheduled start of classes. During orientation, teachers and trainees became familiar with one another. Some were hired for specific settings while others were awaiting assignment. While teachers and social service staff screened applications of children seeking Head Start placement, they discussed the diagnostic services and the special and demonstration classes. No teacher was at this time responsible for either project, however. By the end of orientation week, the seven regular classes were complete with class roster and staff assignments. Only the demonstration and special classes were yet to be organized. However, Head Start personnel were already familiar with the purposes of the classes and anticipated them as integral parts of the Head Start program.

Once orientation was over, BUER and SNAP set about finding a suitable location for the classes, discovering and screening children in need of service, and initiating class operations. After scouring the South End looking into storefronts, churches, community centers and other centrally located buildings, the teachers discovered Union United Methodist Church. The church was hardly ideal for preschool classes, but the minister was anxious to involve his church in community activities. As a result, renovations were planned to begin shortly as a joint enterprise of BUER, SNAP and ABCD. Union Methodist, then, became the site for the demonstration and the special Head Start classes.

Once the site for the classes was established, BUER set about finding children to fill the classes. Among children who had undergone diagnostic procedures the preceeding summer, very few were recommended for the Head Start Special class. The one hundred twenty children who attended summer Head Start were selected in ways which were likely to exclude children with severe problems. Either Head Start did not attract families with disturbed children, or some children had been dropped from the program during screening of applications. BUER and SNAP contacted several social agencies and community programs to describe the diagnostic services and the special class. Some agencies replied immediately supplying information as to names of children who needed special services and ways to contact parents. South End welfare workers advised SNAP of fifty-five children eligible but not enrolled in Head Start and six children who were possible candidates for the special class. Welfare workers introduced BUER staff to families and, with permission, gave social histories so that parents would not be discouraged by the need to give detailed information. The Children's Protective Service referred one more child whom they followed throughout her stay in Head Start. The SNAP Family Service Clinic contributed to the case finding effort in several ways. First of all, they worked with teachers and neighborhood workers screening applications for Head Start eligibility while selecting out children with slow development or behavior problems. They also referred many children, some of whom came from particularly disturbed homes. Though some of these children showed no signs of disturbance, the Family Service Clinic believed that a special class would be beneficial to them either as a resource for long term placement or as a temporary expedient. Then, throughout the year, Family Service workers maintained careful social service support of families with Head Start children.

Next, a teacher and an aide were hired by SNAP and BUER to run the special Head Start class, and they began visiting the families of sixteen children to inform them about the classes and procedures for entrance. The parents were generally receptive and eager to discuss details of their child's development and aspects of his behavior which were abnormal. While the teacher spoke with the mother, the aide played with the children freeing the mother during the visit. When weather permitted, the assistant played outdoors with the children while the mother remained inside with the teacher. This tactic put parents at ease and allowed them to express more freely their fears about their child's problems. Moreover, it allowed aides to gather information about a child's relationship with his siblings and his responses to a stranger in the home.

Parents made appointments to bring their children to the center. Most arrived with other young children including babies. The diagnostic nursery sessions were informal; psychiatrists, teachers, parents and children of all ages were simultaneously a part of the classroom. No observation facilities were available to separate children and parents, and, as a result, many parents entered into activities with their children.

Of the ten children referred for screening during the first month, eight were selected for the special class and two for the demonstration class. Nine out of the ten enrolled. Classes began a month later and were composed of children well known by the staff.

Although the demonstration class and the diagnostic services were developed partly as a facility for Head Start teachers, both were of little use at first. Staff were unable to take time out to visit other classes, and teachers meetings did not allow adequate time to discuss children after the other business of the week was finished. The playground was a good setting to observe children but inadequate for discussing children. If a child was referred by a teacher, the psychiatrist observed the classroom and then brought the child to Union Methodist for a diagnostic session. Only occasionally did teachers accompany their children to the diagnostic session and participate in the succeeding staff meeting. Recommendations for dealing with children were often a burden rather than an aid to teachers who thought they were already overworked.

At mid-year, another teacher was hired for Union Methodist, thereby freeing one teacher to coordinate the diagnostic services and help other teachers implement recommendations of the diagnostic team. Also at mid-year, teachers revised the format of their meetings. They decided on content, arranged for films and speakers, and chaired the meetings themselves. This new format allowed teachers more time to get to know one another and to discuss diagnostic services. The demonstration class was of particular interest to them; they were disturbed that it was held when they were teaching and therefore not able to see it. After long discussion, they decided that the facility should also be used as a laboratory with materials and resources where teachers could bring children to experiment, observe and discuss. They observed that all teachers were potential diagnostic team workers, and that the psychiatrist and the Union teachers were there to teach, demonstrate, and experiment with different educational techniques.

The organizational change in teachers' meetings also led to a change in emphasis of ensuing dialogue. Teachers no longer concentrated on chronic, overt behavioral problems in their discussions about children; rather they discussed children in relation to one another and more subtle aspects of behavior.

As the year progressed, various problems were the focus of interest for the teaching staff. Tremont Methodist Church, a center housing two day care classes, was a center in turmoil throughout the year. One Tremont teacher was anxious for the help of the diagnostic staff. Together, the teaching staff devised a tentative plan for a diagnostic nursery session for a group of five Tremont children. Their teacher claimed that the children were particularly resistent to work which involved sitting down and performing tasks requiring fine motor coordination. These children were going to enter public school the following year. They had been together as a group for more than three years and clearly had a ringleader. When separated, however, the five children were all reasonable and easily handled. The black parents of the children were a militant group, and were hostile toward the white teacher. They were particularly insistent on two points: First of all, they thought their children should be learning to read and write so they would be prepared for public school; secondly, they believed that the racial balance of the teaching staff should reflect the racial balance of the class -- therefore a black head teacher.

To aid the Tremont Methodist teacher in finding more appropriate ways of handling the five children, the teaching staff planned to bring the children to a diagnostic clinic. The Union Methodist observation facility was not, at that time complete, and as a result, the teaching staff opted to use the psycho-educational clinic facility at Boston University. The children were first observed in their own class setting and in another group setting. The Tremont teacher and her aide then planned a diagnostic nursery session to approximate their regualr classroom procedures in order to show the clinic staff the problems that existed in the class.

However, this diagnostic program was never initiated. The children's parents and the minister of Tremont Methodist Church successfully intervened and blocked the operation of the diagnostic clinic, thereby bringing forcefully to light their various reservations about BUER's whole enterprise, and political influences on the clinical and educational programs.

While the teaching staff was joining in planning a diagnostic program for the children, BUER staff met to discuss the role of the university in dealing with that church and the role of that minister as a de facto director of the center and spokesman for the community. BUER resolved to encourage parents to express their concerns and to help BUER find possible solutions to their questions so the clinical programs would not be impaired by jurisdictional disputes.

The minister of Tremont Methodist Church was also the Chairman of the Board of SNAP, though he was not intimately involved in BUER's diagnostic program until the 1967-1968 year-round program. The minister expressed growing concern over BUER's involvement in Tremont Methodist Head Start classes. He asserted that the church had run preschool classes for many years and had an educational committee who remained interested in the program, the teachers, and the treatment of the children in the church. Though he acknowledged that he had no direct power over what went on in the classroom, he added that the church board and the education committee would intervene whenever they believed that an activity was either physically or emotionally harmful to the children. He was not happy with one teacher's performance, though he had recommended her to SNAP's personnel committee for employment, and he believed she should not be maintained in her position. Moreover, he thought it inappropriate to make an issue of the problems of some of the children. The children's parents, he claimed, were troublemakers and their demands did not represent the wishes of the entire parent body. (Recently, these parents had been very active in the center's parent group which had enforced a ruling that no one other than parents would be allowed to attend meetings unless invited -- a ruling which affected the minister first and foremost.) Finally, the minister claimed that other programs in the South End were duplicating the efforts of BUER's diagnostic services, and that BUER was not needed. BUER later met with the other program in question and discovered that, in fact, the two programs did not duplicate but rather complemented one another. the services were so meager that duplication and triplication were essential. The minister concluded by saying he would not permit any BUER involvement with Tremont classes, nor would he acknowledge that parents had requested to have their children evaluated by the diagnostic team. He claimed to be representing the feelings of the community that too many university groups were exploiting the black community while doing research which served no immediate or long range purpose for the community itself.

After the meeting with the Tremont minister, the diagnostic coordinator met with parents to review their concerns about the significance of the teacher's race in the formation of identities and self-images of the children, and the adequacy of the curriculum content for preschoolers. At this and subsequent meetings, parents expressed displeasure over BUER's participation in the Head Start classes. They asked that BUER not work with individual children unless specifically requested by individual parents. In addition, they discussed the possibility of including more black oriented subject matter, including books authored by and illustrations of black people. They requested more urban materials, pictures, and credit given to black heritage, history and holidays. At later meetings, parents reviewed several books and were given bibliography compiled by BUER of available books. Finally, parents concluded that the diagnostic coordinator should be allowed in the classroom to observe the teacher and the class and to give feedback to the parents and teacher. In addition they sanctioned the services of the diagnostic team for any child referred by parents.

BUER's confrontation with the parent's group and the minister was a critical event of the 1967-1968 year-round program. Through this confrontation, BUER began to form a more satisfactory rapport with the community at large and with parents of the children involved. The intricacies of the concerns of various groups became clear, and differences in values began to show themselves. The parents became cognizant of the fact that they could organize a pressure group strong enough to have a voice in the Head Start policy making. The minister also asserted his power in trying to protect children from what he believed to be harmful practices while preserving affiliations useful to the church and the community. In the confrontation BUER was able to make its position clear. The diagnostic clinic was a valuable service to the community, but while running the clinic, BUER had the responsibility to research and report its findings.

Throughout the year, BUER continually modified its procedures. The diagnostic team spent considerable time revising family interviews, diagnostic nursery session plans, and types of feedback to parents during and after formal diagnostic procedures. Some procedures were modified by physical necessity. For example, whole families were included in diagnostic screening because no observation facilities were available at first. Family interviews were waived when an interviewer encountered families who would not open the door unless BUER could promise a class for their child to attend. Staff met with total families when requested by parents. The psychiatrist spent much of his time in classrooms to gain the confidence and support of teachers and parents. The 1967-1968 year-round program was characterized by improvisation and innovation. BUER experimented with a variety of techniques for dealing with teachers, parents, and the community to discover how the Clinic could best service children.

Summer of 1968

Anticipating the more formal summer Clinic, BUER began in early spring to involve the community in planning of the summer Head Start program. For a full year, BUER had tried to make its program meaningful to the community which it serviced. Continually, however, various spokesmen for the South End expressed disapproval over BUER's activities. The Board of Directors of SNAP approved the operation of diagnostic services in conjunction with Head Start for the following year, but asked that BUER make itself responsible to the Parent Policy Advisory Council (PPAC) of Head Start. Guidelines for BUER's involvement with Head Start were drawn up stating, in effect, that the importance of Head Start to the community must be viewed in the total family context. Most families have not one but several children, many of whom have problems. BUER was requested to use its expertise in providing resources to combat not only problems of preschoolers but of others as well. BUER became more sensitive to community feelings, and by the start of the summer program, a large number of community groups had been consulted in planning.

Several community members were hired to serve as community workers and classroom observers. One community worker had been a Head Start parent and was presently an active member of Union Methodist Church. A second worker had been extremely active in Head Start as well as several other community action programs. During the summer of 1968 phase of the program, the role of the observer became flexible and expanded. BUER observers not only attended classes but also referred children directly and sometimes participated in work-ups. In previous years, a child was not referred if either the parent or the teacher was fearful of the step. Observers helped teachers by noting early adjustment patterns and supporting teachers' observations about children's problems. Often, observers talked with parents both in classes and at home. Some observers expressed some confusion about their role but were quick to add that they enjoyed the flexibility it allowed them. One observer recalled, "At this point, I knew very little about my role as an observer but found the people with whom I was working to be genuinely nice and a real joy to work and to be with. So I took part in all activities in the classroom, dealt with the children individually, went to their homes with the neighborhood workers to inquire why they were absent, went to the hospital to get cards for children who had to have shots and did just about anything that came up." Most observers consulted with teachers regularly and occasionally suggested other members of the staff for consultation. Although freedom and lack of direction was uncomfortable for one of the new staff members, most observers found various ways of relating to the class and the teacher and etched roles for themselves which were productive for diagnostic services as well as summer Head Start.

The summer of 1968 phase was characterized by better collaboration between Head Start staff and BUER in solving problems in the classroom. To the surprise of both staffs, a large proportion of the children attending classes that summer were Spanish speaking. Most of the children were not only new to the program and the South End, but also new to the mainland. These children filled openings in the early weeks of the program as well as those caused later by attrition. The teaching and diagnostic staff were faced with the problem of providing a program for children with no English to be given by staff who spoke little or no Spanish. Only one assistant teacher and a few volunteers were fluent in Spanish. The teaching and diagnostic staffs used one another as resources and held workshops in materials, approaches, and techniques for working with non-English speaking children. Working together on such a problem solidified the relationship between SNAP teachers and BUER.

Diagnostics of Staff Children

To better acquaint the staff with the methods of the diagnostic team and to service staff children, BUER suggested holding diagnostic sessions for staff children. Many parents working with Head Start and its ancilliary programs displayed interest in having their children participate whenever the idea was suggested. By the summer of 1968, enough parents were anxious to have their children seen to warrant planning a session. All of the parents had seen the diagnostic clinic in operation with other children. Of the five families involved, one mother was employed by SNAP as the Educational Director for summer Head Start, and another was the sister of the teacher of the Demonstration class. Both had held the responsibility of interpreting the findings of the diagnostic team to teachers and parents. Two other mothers were employed by BUER; one was to be coordinator of the evaluation for the year-round 1968-1969 program, and the other had been on the staff for two years and had been chosen initially from the community to be a parent interviewer. Later she became a classroom observer and tester, and then, during the summer of 1968, she was the second teacher in the diagnostic class and a part of the diagnostic team. The fifth parent was at that time the secretary of Union Methodist Church and had been, for the past year, a valuable link between the church, Head Start and BUER. She joined BUER in September 1968 and became an observer-tester and a diagnostic team member because of her interest.

The parents had a number of specific reasons for wanting their children to undergo diagnostics. One mother was worried about the language development of her child. Others were curious about the effects of older siblings on preschoolers, the effect of a working mother on young children, and the significance of certain relationships between siblings.

The diagnostic team encouraged staff parents to participate as much as possible in observation and work-up procedures. The parents met with the psychiatrist, psychologist, diagnostic teacher, coordinator, and consultant, all of whom they chose, to discuss the process and plan a strategy to meet their specific needs. Everyone agreed that parents should participate in all of the processes, and that at the end of the sessions, they would be given a report of their child's behavior.

The procedures following were rather different than those of the regular diagnostic services. First, parents met with the diagnostic team to discuss their aims in having their children participate and to plan sessions for the children. The kind of teaching style and the activities to be used were considered. Two 90 minute sessions were planned to bring out information about relationships between siblings and adults and discrepancies between their children's behavior with parents and with other adults. Two rooms were used on both mornings, one set up for large motor activity and the other for quieter more confining activities. Basic routines included a snack and struck a balance between structured and freer activities. Parents who had questioned the effect of older siblings on their children were encouraged to bring them to diagnostics the first day for observation. During the first session, parents brought their children to the classroom and got them started on an activity. They then took their children across the hall to introduce them to the teacher. The entire group of children slowly met in the second room while parents left to join the diagnostic team in the observation booth. A Stanford-Binet was administered to each child individually with his parent(s) looking on. Then parents were given a revised outline of the clinic's parent interview and asked to fill it out at home. Specific questions about a child's development were asked, but the outline allowed parents freedom to say as much or as little of the circumstances of their homelife as they wished. Only those problems parents wished to discuss were to be dealt with during diagnostics. Parents were then asked to be full participants of diagnostic staff meetings to discuss behaviors and formulate recommendations. They met twice and received feedback on individual test results and the two diagnostic nursery sessions.

The diagnostic staff meetings included lively discussions of the test situation and the diagnostic nursery. Parents were quick to contribute anecdotes of their child's development and ask questions about his skills. If a parent was concerned about his child's intellectual development, the diagnostic team reviewed appropriate aspects of the child's test behavior. For example, one parent, who was initially concerned about her son's language development, was given feedback on how he performed on the verbal items of the Binet. Other parents received feedback on certain aspects of the diagnostic nursery sessions. In addition, the staff meetings served to generate discussion of broad areas of child development not considered in former staff meetings. Parents and diagnostic team discussed such issues as what is the rationale behind insisting that children obey certain rules of sanitation such as washing their hands before eating? Are we giving them a model for what should eventually become a habit,or are we preventing them from becoming ill? If a child tends to use only one color in painting, is he passing through a particular developmental stage, or is this behavior related to the psychological functioning of the child? Is a child's choice of certain colors related to his feeling about toilet training? The diagnostic team lent theoretical support to the parents' discussion, and parents acted as consultants to one another on the basis of varying backgrounds and experience.

The most urgent issue facing these parents, however, did not appear until well along in the 1968-1969 year-round program. About mid-year, one parent reported that her sons, according to his public school teacher, was immature, had demonstrated a short attention span, and was doing poorly in learning the basics of reading. Her child had tested very highly at the Clinic and showed a high degree of concentration, excellent verbal ability, and knowledge of reading basics well before his entrance into public school. His mother had little doubt that her son was bright. She had experienced raising bright children before and knew the problems inherent in the process. Her question was, how can you raise exceptionally bright children when you are trapped by circumstances which leave few or no alternatives to public school education? This mother's problem was shared by many of the staff members with children. All of the children undergoing diagnostics were precocious in some aspect of their development. Although each parent was concerned about some specific developmental areas, they all were faced with the same problem: Once they were assured that their children were indeed bright and maybe even exceptionally bright, they were faced with the task of stimulating children likely to be bored in public schools.

The diagnostic service for staff children was among the most productive experiments tried during the summer of 1968. Encouraging parents to become intimately involved in the diagnostic procedures gave staff more insight into the process and allowed them to speak more confidently to other parents during or after diagnostic sessions. The inclusion of community members as observers and a parent group as planning consultants also contributed to improving the relationship of BUER in the community.

Year-Round 1968-1969 Phase

The year-round 1968-1969 phase differed from the previous year's model in that BUER's activities permeated every aspect of the South End Head Start. BUER dealt with teachers, children, parents, and classes, individually and collectively. It dealt with everyday classroom problems, and specialized problems of exceptional children.

Observers participated in all aspects of the diagnostic process and were the most important link between the classroom and BUER. A social worker acted as a liaison between SNAP's Family Service Clinic and BUER while the former coordinator of the Clinic filled the joint position of BUER research associate and educational supervisor for SNAP Head Start. A community leader interested in community relations and parent involvement joined the BUER staff. Both community workers from the summer program as well as the former secretary of Union Methodist Church became observer-testers. Fifty percent of the Head Start teachers were new to the program, but fifteen out of seventeen assistant teachers were experienced. The administrative and supervisory staff of Head Start had all worked with BUER in one capacity or another. Due to the large number of experienced personnel and the increased percentage of community members on the staff, BUER had fewer problems relating to the SNAP staff and the community than in previous years.

The previous year's routine for screening children was adopted and diagnostic sessions for children referred by teachers, parents, observers, or workers were held once a week. Children were followed more consistently in classes due to better cooperation among SNAP, BUER and the teachers themselves. The special class was supported as before, and the diagnostic services enjoyed the luxury of being known, accepted and therefore aided by other services such as the Family Service Clinic.

The observation facility itself was complete and used freely in a variety of ways. Teachers brought children to Union Methodist for tutoring and asked diagnostic staff to observe or participate. For training purposes, trainees directed and observed a demonstration class composed of selected children from their classes. Prospective Head Start parents observed the demonstration and special classes at the facility and were thereby introduced to both Head Start and BUER's work with classes. BUER also set up demonstrations and workshops to inform parents about other aspects of its program.

The availability of the diagnostic staff allowed teachers to discuss children whom they considered problems more easily. For example, one teacher discussed six of her children with the educational supervisor who observed her class frequently. Further discussion with the diagnostic team led the teacher to change her approach with the children and contributed to smoother running of the class. As before, one center suffered from a poor physical facility, inexperienced teachers, and interfering center director, and uncooperative parents. This time, however, the teachers with the help of BUER were more successful in coping with these circumstances. One teacher set up and directed diagnostic nursery sessions for six troublesome children and remained open to suggestions from the staff. She participated in the diagnostic staff meetings and incorporated the recommendations into her teaching style. The effect on these children was immediate, and many of the class' problems were eliminated by the use of a different set of tactics. Bringing the children to diagnostics did not, by any means, solve the problems of the entire center. But within one class, the teacher and children began to enjoy a more positive emotional climate.

Staff parents also continued to enjoy the assets of the diagnostic staff. One day a week was set aside for staff to discuss their own children with any members of the diagnostic team. Most frequently, the psychiatrist spoke with the parent while another team member interacted with the child in the same room. But sometimes the psychiatrist held sessions with parents and children together, while at other times he spoke with the parent while they observed the children in another room.

The year-round 1968-1969 diagnostic program operated more smoothly than before. BUER staff became an integral part of Head Start classrooms, and parents, for the first time, participated in and supported the program.

Summer of 1969

During the summer of 1969, BUER experimented with a new model of collaboration between teachers, neighborhood workers and diagnostic team members. Early assessment of children remained BUER's goal, but the means of attaining that goal was entirely renovated.

Each classroom unit was redefined to include not only the teacher, aide, and observer, but also a neighborhood worker and a consultant who had formerly been a member of the diagnostic team. Consultants came from a variety of disciplines: Some were psychiatrists; others were social workers; some were interested in community relations; others were specialists in educational and psychological measurement; still others were experts in methods of teaching English to Spanish speaking children. The roles of the consultants and observers were not predetermined but rather left up to the individual and team. Teachers, observers and consultants were all given the opportunity to choose with whom they wished to work.

Each classroom unit was paired with one or two others, according to interest in what was termed a cluster. Instead of formal diagnostic sessions, each cluster met weekly to discuss problems and accomplishments of children and teachers in its classes. One cluster was interested in the integration of

Spanish speaking families into the community. Another cluster considered situational problems while a third held general discussions about their classes. All of the clusters spent some time discussing children with special needs though none of the three placed major emphasis on assessment. Parent involvement, curriculum planning and needs of Spanish speaking families received much though not always equal attention from the clusters. Some activities, such as videotaping, were used in all clusters.

In addition to cluster meetings, teachers, consultants, and neighborhood workers all held their own meetings. The teaching staff met to discuss curriculum content and assessment of early adjustment patterns and gave workshops designed to demonstrate methods of building classroom materials. Consultants met to discuss topics aired in cluster meetings during the week and to form a composite picture of the functioning of the three clusters. Neighborhood workers considered their continual problems of recruitment, attendance, and attrition. Although supervisors saw a need for these specialized meetings, participants were dissatisfied with the amount of time they required.

In evaluation of the summer model, participants claimed that the cluster system was confining. They missed the chance to consult with the psychiatrist and various other consultants not in their cluster. Others insisted that they were not able to attend to their jobs sufficiently because of the number of meetings to attend. In the smallest cluster, however, consultants and teaching staff had interacted informally, and these participants thought the new model to be very effective.

Conclusion

From 1967 to 1969 BUER experimented with a number of different tactics and procedures, some more successful than others. The aims of the program remained the same, but methods of achieving those aims fluctuated constantly.

Early in the two year period, BUER recognized that concerns of the parents and the community had to be reckoned with if the program was to succeed. From that point on, BUER expended much of its energies involving parents in the planning process and giving them educational alternatives from which to choose. In the same way, BUER had to enlist the aid of the Head Start teachers. Teachers had to be educated as to possible causes of disturbance in preschoolers and more importantly ways to alter teaching style to cope with disturbance. Both teachers and parents had to be reassured continually that BUER was sincerely trying to help children and not simply invade the privacy of the classroom and the home.

As time progressed, however, the South End came to accept and support BUER's activities. Experimentation and change became the order of the day and not something to be feared. Individuals who were once uncomfortable in their ill-defined roles began to enjoy their flexibility. Rapid turnover of staff still interfered with the continuity of the program, but new staff were more quickly assimilated into the program once the existing procedures were accepted and supported by both staff and the community.

Setting

The constituency of the Clinic did not become stabilized during the period of time that we were in the South End. The Clinic was viewed as many different things -- from a hospital to a social club. The problem of getting a "name" which would bring parents who needed help to the Clinic, particularly the kind that might be available, was very much tied up with problems of treatment, no matter how unconventional they might have been. In the beginning, very few children were referred to us -- it was like asking if anyone had an obscure disease that no one had ever heard of; no one admits to the disease. As information about the Clinic's activity was passed around the community, more and more children needed service, and there was more discussion by parents about normal and abnormal behaviors of children -- which then led to discussions about behaviors of parents.

The Clinic, then, was a place to service and study children with moderate to severe problems. It also became a center for teachers, supervisors, observers, parents and other professionals. It was a setting to discuss and debate about children, discipline, teaching, testing, child-rearing and race. Teachers sometimes brought groups of children into the classrooms where we had constructed adjacent observation rooms. Clinic staff, parents and other teachers and trainees would observe and discuss their observations. There were continual consultations between individual teachers and members of the Clinic staff. One teacher was taking a course in play therapy and was supervised by our psychiatrist.

This led to discussions of play therapy with parents and other teachers and became a great source of stimulation to many of the teachers. Other teachers became involved in discussions of individual children and families both in the formal context of the Clinic as well as in the informal getting together that went along with the Clinic program.

This was the kind of setting that was appropriate for dealing with our stated problem: Who is disturbed? What is disturbance? What can be done about it? By whom? We developed a setting where exchanges could take place. Without such a setting,the lines would have been drawn before we started. Emotional disturbance would have been another disease which afflicted some but not others, rather than a connection between a preschool program and a community. South End parents had little need for another sickness, but they had a desperate need for an educational system that included children with problems. For most parents, schools are distant, powerful, unchanging, but right. Teachers are specialists who can occasionally be spoken to, but never questioned. Children behave as they do because of themselves, not because of the school environment in which they are placed. Therefore, children should be disciplined when they do things "wrong" because it is necessarily their fault and not the schools. This view of schools, behavior, teachers and interactions has important implications for the understanding and study of emotional disturbance (Sarason, et al, 1966).

To create a setting is to set up a framework for viewing behavior. A setting is "created" by either going into an existing agency, or by developing a new agency or an adjunct to an agency. The issue is that disturbance, or any other phenomena, will take on a form that is, at least partially, unique to the setting where it is studied. Place a clinic in a hospital, public school, community center or store front, and services, clients and reactions will be different for each. Staff will see different kinds of cases; a cut-off between normality and abnormality will be conceived of and acted upon in different ways; varying "traffic patterns" will bring staff and clients into contact with different professionals and non-professionals; casual contacts between staff and potential clients will be different. The setting is crucial to what is studied and how it is done. We have carefully described the action principles and development of our setting. The children and families with whom we worked for three years were very much a part of, and affected by, that setting.

As our setting developed, it affected the kinds of data we obtained, which, in turn, affected the further development of our setting. Our views about language, alternatives and roles are certainly derived from the South End setting. Before generalizations can be entertained, we have to come to grips with explanations -- the internal validity of our setting as it functioned, developed and collected data. But even before explanation we have to be able to view the landscape and share that view with both professionals as well as members of that community. The description of the development of the Clinic provides a brief view of this setting. Remaining sections of this monograph describe the Clinic population both in fairly general terms, as well as in the details of case materials on individual children and families who were seen.

Survey

During the several phases of the Clinic (1966-1969) we were actively involved with one hundred and twelve (112) children, but several hundred additional children were directly affected because of the Clinic's supportive relationship to teachers and parents. Even more importantly, the Clinic staff assumed, from the very beginning, that its function was not only to deal with crisis, but also to become deeply involved in prevention. This meant working with a far wider population of teachers, parents and children than that which can be formally designated as being "emotionally disturbed."

The following fifteen tables present summary data on the total Clinic population for the three year period. These tables provide a very general picture of the children and family scene, family size, referral history, age, sex, findings, recommendations and follow-up activities.

Tables

A relatively high percentage of children had siblings in diagnostics (45%). The percentage of males was 66%, which is usual for clinics in all social classes and for all ages through twenty-one.

Although the primary reason for referral was "emotional" (40%), the findings showed only 16% to be "emotional," 24% to be essentially normal, and 30% to be situational -- the classroom and/or family situation was directly precipitating undesirable behavior. 77% of the cases were dealt with directly

Charts - South End N=112

I. Siblings in Diagnostics

62/55% did not have siblings in diagnostics
50/45% did have siblings in diagnostics

II. Siblings in Family

12/11% had no siblings in family
99/89% did have siblings in family

III. Referral Sources

Sources	Freq.	Percent
Mother	14	13
F.S.C.	22	20
Social Worker	3	3
H.S. Teacher	39	35
Neighborhood Worker	9	8
Staff Child	8	7
Other	16	14
TOTAL	111	100%

IV. More than one referral

98/88% had only one referral
14/12% had more than one referral

V. Ethnic Racial Origin

Race	Freq.	Percent
Caucasian	8	7
Negro	76	68
Puerto Rican	24	21
Chinese	2	2
Other	2	2
TOTAL	112	100%

South End (Cont'd)

VI. Sex

74/66% Males
38/34% Females

VII. Duration of Contact

Mean - 7.2 Standard Deviation = 7.64

56/50% had two months or less contact
39/35% had one year or more contact

VIII. Family Constellation

Mean = 5.0 Standard Deviation = 2.81

IX. Family Intact

54/50% missing one or both parents
54/50% both parents present

X. Date of Birth

Mean/Average Date of Birth = 63.7

Standard Deviation = 1.49

XI. Age (when seen)

Mean/Average age when seen = 4.5

Standard Deviation = 1.34

Range: 1 yr. to 9 yrs.

Percent between 3 yrs. to 6 yrs. = 84%

XII. Reason for Referral

Reason	Freq.	Percent
Emotional	45	40
Intellectual/Perceptual	16	14
Physical	14	13
General Eval.	23	21
Multiple	6	5
Situational	8	7
TOTAL	112	100%

South End (Cont'd)

XIII. Referral Findings (for Category "Referral")

Referral	Findings	Freq.	Percent	Total Freq./Percent
Emotional	Behavior	9	8	18/16%
	Withdrawn	2	2	
	Hyperactive	1	1	
	Immaturity	1	1	
	Other	5	4	
Intellectual/ Perceptual	Retarded	5	4	15/13%
	Poor Lang. Dev.	6	5	
	Lack of Stimul.	1	1	
	Refuses to speal	2	2	
	Other	1	1	
Physical	Physical Handicap	1	1	8/8%
	Poor Physical Dev.	2	2	
	Poor Hearing	2	2	
	Other	3	3	
General Eval.	Normal	27	24	27/24%
Multiple	Emotional/Intell.	3	3	5/5%
	Emotional/Physical	2	2	
Situational	Family Problems	29	26	33/30%
	Class Problems	2	2	
	Other School Prob	2	2	
	No Follow Through	6	5	6/5%
TOTAL		112	100%	112/100%

XIV. Recommendation

Type	Freq.	Percent
No action	6	5
Clinic	85	77
Referral	17	15
No longer involved	3	3
TOTAL	111	100%

South End (Cont'd)

XV. Follow Through

	Follow Through	Freq.	Percent
No action	No action	12	11
Clinic	Special H.S.	14	13
	Regular H.S.	31	29
	Treatment	1	1
	Therapy (Emot.)	4	4
	Transitional	4	4
	Home	3	3
	Public School	11	10
	TOTAL	*68	*64%
Referral	Family Service Clinic	1	1
	Testing	1	1
	Hospital	2	2
	Social Service	1	1
	Other	3	3
	TOTAL*	*8	*8%
No Longer Involved	Moved	8	7
	Lost Contact	6	6
	Never brought to Diag.	5	5
	TOTAL*	*19	*18%
	GRAND TOTAL	107	100%

by the Clinic, and at the end of the three year period, 64% of all cases were, in same way, still involved with the Clinic.

These tables provide an extremely cursory view of our population. The case material, to be presented below, gets more into the depths of both our activities and our population and more validly illustrates the unique problems that we faced in the South End as well as our responses to those problems. Extraordinary populations are difficult to describe in survey terms because there is so little comparability across cases and situations. Survey questions demand some kind of "all things being equal" assumption across cases. We were repeatedly up against an "all things being unequal" state of affairs. Therefore much of the data selected across cases could not be presented. The survey data presented must be considered in this light.

Case Study Material

The variety and causes of emotional disturbances found in preschoolers from Boston's South End illustrates the inadequacy of the use of middle class oriented diagnostic procedures with lower income multi-problemed families. In the ghetto, emotional disturbance arises in home and school situations improbable or nonexistent in middle class society. That many lower income children have behavioral problems is not surprising considering the environment they face daily. To understand the individual's sickness, one must also take into account society's sickness, for the two are intimately interrelated.

In the same way, one must consider the realities of life in the lower income community to discover effective procedures for treating disturbance. Clearly, some middle class conventions are not at all appropriate in the ghetto. A lower income parent often can not drive her child to the psychiatrist's office once a week; nor can she afford to send her child to expensive private schools when no suitable public program is available. Effective treatment of emotional disturbance in lower income communities requires a realistic view of alternatives open to parents. The psychiatrist, psychologist, and social worker must all be aware of the unique concerns of the lower income community. Middle class values must be reexamined, and conventional roles must be revised. The psychiatrist may discover that he is most effective in the classroom; the psychologist may learn that conventional testing procedures are innacurate;

the teacher may discover that conferences in the home are most helpful. Flexibility in attitudes and roles is essential to the administration of an effective program.

In addition to the other problems inherent in treating emotional disturbance in lower income communities, one also has to cope with the seeming indifference of parents. Very often, parental participation is essential to effective treatment of emotional disturbance in preschoolers. Yet stimulating this interest is a time consuming frustrating task. If parent involvement is stimulated and if parents are given educational alternatives for their child, the treatment can be very effective.

Developmental Problems Attributed to Ghetto Living

Many of the apparent developmental problems of preschoolers in the South End were situational and could be attributed, in large part, to the effects of ghetto living. One Puerto Rican boy, for example, was referred by his teacher because of retarded language development. A social worker discovered, by going into the home, that his family lived in a tenement with four other Spanish speaking families. Because of the neighborhood, the parents would not allow the children to go outside. As a result, the boy had grown up in the small apartment with his three younger siblings. Such an environment gave him no chance to learn English and little incentive to speak Spanish. Another child was referred for a similar language deficiency. Interviews revealed that he was left alone all day with his deaf grandmother while his mother worked. His home was apparently devoid of intellectual stimulation. No television, books or other forms of intellectual stimulation were in evidence.

Children Suffering From Unstable Home Lives

Very often, lack of stimulation at home combined with an unstable home life and emotionally disturbed parents, contributed to a child's retarded development and his own emotional disturbance. One boy, Ted, was referred due to many symptoms characteristic of autism. In an interview, a teacher learned that Ted's mother was separated from her husband and supported Ted and his three half brothers through welfare funds. They lived in a neat, clean, but extremely run-down, apartment, part of which had been condemned. Ted's mother reported that he was a normal happy baby until he was three months old. At that time he suffered a head wound, the origin of which she would not describe. As a result, he was operated on, and a scar ressembling a healed laceration was still visible on the back of his head. His past medical record suggested no resulting complications. Apparently, the trauma served as a focus of anxiety and guilt for Ted's mother. She claimed that her husband made her keep the baby in the cellar for three years because he regarded Ted as a freak, but that she stayed with him and even slept in the basement. Now, she thanks God that Ted's father sees the child as "human" again.

Another child, Bobby, was referred to BUER because of his poor coordination, persistent drooling and violent temper. An observer was concerned because his mother reported that he had often threatened to kill someone grabbing a kitchen knife as a weapon. An interview was arranged immediately with Bobby's mother. When the observer arrived, Bobby's mother and his three siblings were waiting on the front steps. The children were playing quietly; two had no shoes on. Bobby's mother was extremely friendly and open throughout the interview. Most of the interview consisted of a discussion of her husband's drinking, her illness, and her fears. Bobby's father was apparently drunk frequently. His mother kept a bottle of lye in the house for protection because she learned that her husband had beaten his first wife to death. When drunk, her husband beat her and the children, and as a result, the children resented him. On the other hand, he played with the children and was affectionate only when he was intoxicated. She mentioned repeatedly that the children loved her and not her husband. She went nowhere without the children and, in turn, the children were very protective of her. They spoke of their father as "father" only out of respect to her.

At this point in the interview, Bobby's mother took the observer upstairs into the apartment. Neither of Bobby's parents work. Welfare pays for the children and sends their father to school -- what type Bobby's mother did not know. Apparently a city agency was trying to find better housing for the family. The front door opened into the kitchen which had an old gas stove. The ceiling sagged, and large cracks were visible in all the walls. The cupboards, and, in fact, all the rooms, were teeming with roaches. The bathroom was swarming with flies. An old hole in the floor was covered with a peice of linoleum, and the toilet did not flush. A pipe had burst the day before so that the apartment had no water, and the gas had been turned off that day. In the bedroom was a double bed, bookshelf, television, and record player. Off to the side was an alcove used as the children's bedroom. The three boys slept on a sunken sofa while the girl slept in the crib. Sometimes the four year-old boy slept with his parents as he had no room on the couch. Besides the two adults and four children in the two and a half room apartment, they had three dogs, one cat, and a turtle as pets.

The history of the family was somewhat vague. Bobby's grandmother died when his mother was very young. She was then sent to live with her aunt in Massachusetts. At the age of four, Bobby's mother was thrown out of the window by her aunt. As a result, a gold plate was inserted in her skull. Since that time, Bobby's mother said, she had been afraid of everything: The fear of death obsessed her; she was afraid of darkness and being alone; she was afraid of gas and kerosene; she was afraid her husband would try to kill her and the children; she would not take the children fishing for fear they might drown; they were not allowed to cross the street for fear they might be hit by a car; they were not allowed to play with scissors for fear they might cut themselves seriously. Many of her fears were cloaked in superstition. Evidently, some of her fears were transmitted to the children. All of the children were afraid of the dark. Bobby was afraid of firemen because he thought they would set him on fire. Airplanes upset him, and he covered his ears whenever a plane flew overhead.

Bobby's mother was not clear on the details of the family medical history. Both Bobby and his older brother were born as twins. Johnny was so large that he crushed his twin, and Bobby's twin did not receive enough food during pregnancy. Johnny suffered some serious illness which caused him to lose blood and resulted in anemia. All of Bobby's teeth were rotten, and something was wrong with his tonsils. The two younger children were born in North Carolina. The youngest boy, Bobby's mother claimed, was a "veil baby." He had seen God and could prognosticate events especially concerning his father. Bobby's mother had just recovered from a serious operation during which, she claimed, she had almost died. An intrauterine device was placed improperly causing wide spread infection. Apparently a hysterectomy was performed.

Bobby's mother was anxious to have Bobby attend the Clinic. About a month later, another team of interviewers visited her one day after her husband had beaten her to the point that she needed medical attention. She was scared of her husband and worried about the children for whom she had no food or clothing money. BUER staff advised her to go to welfare for more money and explained how to have a warrant sworn out for her husband's arrest. In the next few days, new housing was arranged, and the mother and children moved leaving no address behind. Bobby's mother was still frightened, however, that her husband would find them. She was urged to keep in touch with SNAP Family Service Clinic.

According to his teachers, Bobby was an appealing child. During the diagnostic nursery session, he warmed up to the teachers and other children very quickly and became interested in the various things to do in the classroom. He was fascinated by the gerbils and rabbits, but was rather rough on the animals, as if he was unaware of the inappropriateness of the amount of force he was exercising to keep them in their cages. He was very concerned, during both sessions, about keeping the rabbit in his cage. He may have been afraid of it for one reason or another. When the teacher charged him with the responsibility of keeping all the little animals safe, he responded by being more gentle with them. Later, he insisted that the teacher read a story to him. He seemed to know most of it by rote. His concentration on the story and his memory were good. He spoke clearly using sentences, though his vocabulary was lacking in richness On the second day, Bobby formed quite a strong relationship with one of the other boys. In a game, he almost became angry when he was not allowed to have an extra turn, but he cheered up almost immediately. The diagnostic teacher concluded that Bobby was resilient, gregarious, adaptable and capable of forming strong relationships with other children. His demand for adult attention was by no means extraordinary for his age group. However, he appeared to be functioning at a slightly retarded level. His performance on the Stanford-Binet bore out this observation. Because of the circumstances of Bobby's home life, the diagnostic team decided that he could best be serviced by referring his family to SNAP's Family Service Clinic and then after the family had moved, to Roxbury Multiservice Center.

Some children with unstable home lives had developed serious emotional disturbances. One child, Billy, was referred to BUER by the Family Service Clinic as a preventative measure because of his mother's emotionally disturbed behavior and the lack of stimulation at home. Billy's mother had a history of manic-depressive behavior. She was born in South Carolina where she began working in the tobacco fields at the age of sixteen. In 1945 she came to Massachusetts, but returned to South Carolina to get married three years later. Her husband was a heavy drinker, and in 1960 they separated. She has five children ranging in age from nineteen to four years old, and she receives $252.00 monthly from welfare.

Billy's mother had been treated several times at psychiatric clinics. She had been hospitalized twice since 1961, diagnosed a manic-depressive. Billy's sixteen year old sister apparently had severe emotional problems also. She was constantly truant from school and still an eneuretic. Her bizzare appearance and her uncontrollable behavior suggested psychiatric problems of some depth.

When the BUER observer first visited Billy's mother, she appeared rather withdrawn and depressed. She was heavy set and slow in speech and motion. Her conversation consisted almost entirely of "yes" and "no" responses to questions. The apartment was messy with inadequate furniture. The building was in such condition that the observer later called the Housing Inspection Department. Two months later, the observer began to notice gradual changes in Billy's mother. The house became neater. She talked at great length on a variety of subjects, and she showed real concern about her daughter's truancy. Then two weeks later, she called BUER to say she had been flooded out of her apartment. Her tone was aggressive and excited. She rejected BUER's offer for help and arranged for new housing herself in another substandard building. Soon after, she visited the Welfare Department and was asked to leave due to aggressive behavior. She then expressed hostility and distrust of both the Welfare Department and BUER. Apparently, Billy's mother had entered a manic phase which had twice before resulted in hospitalization.

Billy himself showed symptoms of anti-social and psychotic behavior. He was placed in the special Head Start class for emotionally disturbed children. Early in the year, he showed varying degrees of impulsiveness and remoteness. His expression was sometimes apathetic and trancelike, and sometimes angry or miserable. At first, he showed little ability to play with other children and was unable to cope with either positive or negative situations. At the end of the year, he was still subject to an occasional emotional collapse, but, by in large, he demonstrated an impressive ability to control himself given the proper incentive. He was a master at manipulating people, and he played extremely well with the other children in the class. In fact, he interacted at the highest level of any of the children and showed imagination and creativity in his play. His teacher recommended placement in a regular summer Head Start class with a strong controlling teacher for lack of any better alternative. September, she urged that he be put back in a special class where a teacher would have more time to work with him.

Emotional Disturbance Related to Traumas

Several children had suffered traumas which contributed to their emotional disturbance. One child developed a nervous twitching of the body when he became upset. His tic originated at five years of age when his mother underwent stomach surgery while, simultaneously, two of his sisters were hospitalized for head injuries from separate incidents, and a third sister ran away from home.

Another child, Robby, had seen his mother attempt suicide. Just one month before Robby's referral to BUER by his teacher, Robby's mother had died of an embolism after several months of confinement at Boston State Hospital. The remote cause of death was an injury sustained several months before when she had jumped from the window of her fifth story apartment. Robby's grandmother had been awakened by a man shouting through the window that her daughter had jumped. At first, the grandmother did not believe him until the man insisted that she needed an ambulance immediately and that blood was all over the sidewalk. Robby's mother was taken to Boston City Hospital. Apparently, Robby was awake during all the confusion and knew exactly what had happened. Due to the fall, Robby's mother sustained brain injury resulting in paralysis from the waist down. Robby was allowed to visit his mother two afternoons a week during her confinement.

Robby's grandmother was very concerned that her daughter had received the message of salvation but not heeded it. Apparently, her daughter had had a few romances in the past five years and even intended to marry some of her boyfriends though she had never divorced her first husband. She apparently traveled to Alabama to marry one man but returned to Boston upon discovering that he was unfaithful to her. During her confinement, Robby's mother was very repentant and promised to mend her ways. She claimed to have made her peace with God and promised to be a better mother to Robby when she was well.

After his mother died, Robby began screaming in his sleep like a crazy person, according to his grandmother. He was often cruel to the cat and extremely possessive of visiting children's toys. Robby's grandmother felt his religion was neglected by his mother. To compensate for this lack, she tried to teach him Bible stories. When she started to tell him the story of Genesis for the second time, he protested saying he had heard that once and that he was not stupid. He then proceeded to repeat the story himself.

Robby's grandmother was concerned about him because she thought him to be quite bright and did not want him placed in a special class as his mother and aunt were. Robby's grandmother believed that his mother's placement in a special class had originally been arbitrary and not related to intelligence. She was never transfered out of the class for the rest of her educational years. Robby's aunt was also in a special class and reputedly did not read until the grandmother insisted she could. She was then asked to read for other classes. Furthermore, the grandmother did not want any psychologist to look at Robby. Psychologists, she felt, took you away from Jesus. The BUER interviewer was a nun, and Robby's grandmother conceeded that anyone associated with a church lady must be all right. To allay the grandmother's fears, the interviewer explained some of the activities the psychologist and the staff would be doing with Robby.

After the diagnostic nursery session, the teacher reported that Robby was an extremely worried little boy. His problems revolved mainly around control of his own impulses and his personal relationships. He was very bright and self-aware. With his intelligence, his ability to state his feelings, and his persistence, he might be able to overcome his emotional problems. The diagnostic team recommended first grade placement for Robby preceeded by brief term psychotherapy at the child guidance clinic to work through his grief. The grandmother was requested to attend also. The team also contacted Family Service to find a male companion or Big Brother for Robby for purposes of identification.

Developmental and Emotional Problems Complicated by Physical Handicaps

Occasionally a child's developmental and emotional problems were complicated by his physical handicaps. One child was referred for hypertension and suspected epilepsy. His brother was retarded, partially blind and palsied. Apparently their parents spoke minimal English and seemed quite helpless. Another child was one year behind in language development due to temporary deafness inflicted by a sustained fever. He had undergone skull surgery the summer before. Because of his delicate health, the diagnostic team placed him in a quiet, well structured day care class which placed special emphasis on language stimulation.

Another child, Jimmy, was referred to the diagnostic clinic due to hearing and speech deficiencies as well as poor physical coordination. Jimmy was born in Puerto Rico. Apparently his birth was complicated with an RH incompatibility as well as jaundice, and as a result, he received a complete blood transfusion when three days old. When Jimmy was one year old, his parents separated, and he was sent to a foster home where he was under-fed and generally mistreated. After five months, his grandmother removed him. At that time, his head lay permanently on his left shoulder, and he could not stand up. Within three months, he could hold his head properly and stand again. However, the hospital at Mayaguez reported to his grandmother that he was mentally deficient. When he was two, the grandmother moved to Boston. Jimmy's father lives with him, and his mother lives nearby though she remarried and has two children by her second husband.

When Jimmy was two and a half, he spent three months in Boston City Hospital. His grandmother did not understand enough English to know precisely what was wrong, but she had the impression that something was wrong with the veins in his neck which prevented him from speaking and that they wanted to take him to another state to operate. She refused, removing him from the hospital and had kept him at home until he first attended Head Start at the age of seven.

Jimmy seemed to understand some Spanish and English, but he spoke no words at all. When he became excited and wanted to communicate something, he made long undifferentiated noises like howling. Only occasionally did he make definate attempts at speech. Apparently he did not have full control of his muscles. He had a very unbalanced gait, and he moved his arms at strange angles. His facial muscles twitched involuntarily sometimes. However, he was coordinated enough to draw somewhat recognizable pictures.

He seemed to be a warm interested child. His grandmother reported that he enjoyed playing with other children, but that they had a tendency to mistreat him. He would often touch their arms and heads, and they would misunderstand his intention and hit him. Sometimes he would come crying upstairs, and sometimes he would simply allow them to hit him until she came down to stop them.

Although previous psychological evaluations had judged him severely retarded, he demonstrated surprising skills at the diagnostic nursery session. From the beginning, Jimmy was a friendly appealing child. He made good eye contact and communicated his wishes readily. His ready adaption to the situation and his recognition of the staff as agents of approval became clear very early in the session. In spite of his limited motor and verbal ability, Jimmy readily communicated his understanding of the uses of things, and he made excellent use of materials. Right away, he became interested in the musical instruments, the drum, clarinet and trumpet. He showed surprising ability in blowing these later instruments. In picking up each one, he identified its match on the charts and then showed the teacher the pictures of instruments absent shaking his head as he did so. He had rather startling motor skills considering his handicaps. He could jump rope, do the hula hoop and work the hand beater better than the other younger but physically normal children.

Jimmy was very amenable to the teacher's suggestions. He nodded vigorously when asked to do something but often did not follow through. The nodding was apparently indiscriminate, for suggestions in English, French, and Italian all elicited the same response. In the second session, the teacher tried to find out a bit more about his language. When looking at books, she asked him to point to pictures of objects like a monkey, an apple, and a hammer. The only picture he recognized repeatedly was a duck, but when asked to say 'hammer,' 'milk,' and'duck' he did so quite clearly. Moreover, he was able to separate fruits and vegetables from toys. To discover the source of Jimmy's language difficulty, the diagnostic team referred him to a speech and hearing clinic and then to Kennedy Memorial Hospital for intensive testing.

The speech and hearing clinician concluded that Jimmy had a hearing impairment which affected his reception of speech. However, she did not rule out the possibility of aphasia. At Kennedy, after five days of audiologic and psychological testing, a doctor concluded that Jimmy had chronic encephalopathy probably related to the RH incompatibility and manifested by mild motor difficuities, central and peripheral hearing loss and an undetermined degree of general intellectual difficulty. He recommended a period of intensive language training with the eventual hope of placing him in a school for the deaf.

BUER arranged for an examination required for entrance into an intensive language training program. However, Jimmy was rejected by the program because of the complexity of his problems. For lack of a more specialized program, he was placed in the Head Start special class.

Parents Unwilling to Cooperate With BUER

Occasionally parents were unwilling to cooperate with the diagnostic team or unable to accept the fact that their child had a problem. One child, Lee was referred to BUER because of his quiet, verbally unresponsive behavior. Lee came from a Chinese speaking home, and his teacher was worried about potential learning problems due to his lack of English. Lee always remained on the periphery. When involved in group activities, he participated nonverbally. During the second week of Head Start classes, a diagnostic team member met with mothers to explain the program of diagnostic evaluation. Lee's mother attended, and afterwards the staff member spoke to her expressing a willingness to supply a special language development program for Lee. Subsequently Lee's teacher suggested several times that he should be evaluated. Finally, a staff member made an appointment to talk to Lee's mother and arranged for an interpreter. However, on the day of the meeting, Lee was absent from school. The staff member and the interpreter then went to his home to discover that Lee's mother and father had gone out leaving his grandmother to care for the children. The interpreter explained to the grandmother the teacher's concern over Lee's problem and the services available for him. But the grandmother said the family had no reason to be concerned about Lee. She claimed that many Chinese children were shy and uncommunicative throughout first grade, but that in second grade, they really took hold of English and would teach younger siblings. The family felt that Lee understood English well enough to do first grade work and that he spoke Chinese very well at home. The teacher, however, had observed that his behavior was very different from the other Chinese in the class who were very verbal in English. Still the family refused to refer Lee. BUER stayed in contact with Lee's first grade teacher so that its services would be available at any time. However, no referral was forthcoming.

BUER had difficulty eliciting the cooperation of many parents, though sometimes their cooperation was essential to successful treatment of their child. BUER was asked to assess the readiness of one child, Kathy, for public school. In the diagnostic nursery session, she exhibited high anxiety, tension and hyperactivity. Her emotional needs seemed to impair her intellectual functioning. Though she occasionally showed signs of intelligence in sizing up situations and in displaying her sense of humor, her lack of social skills and her emotional needs overshadowed any strengths. When tested on the Stanford-Binet, Kathy achieved an IQ of seventy-three. The examiner, however, thought that score was depressed due to emotional problems.

Kathy was also physically handicapped. At ten months, she suffered two seizures necessitating hospitalization and surgery to remove two sacks of fluid from the brain area. Apparently, one side of her brain received some damage so that development of her right side was retarded. She walked with a semi-scissor gait on the right and carried her arm in a pronated, flexed position. She underwent physical therapy regularly and had a brace for her legs.

Kethy was cared for by her grandmother who was proud of her accomplishments and who repeatedly bragged about her precosity and intelligence and was rather unrealistic about her abilities. The grandmother was apparently very religious. She credited God with Kathy's recovery and taught her Bible verses and stories. However, she seemed rather disoriented and almost paranoid about letting Kathy out among other people. At mid-year she took her out of her Head Start class because, the grandmother claimed, she had been beaten up. The truth was that she had been accidently injured slightly, but her grandmother exaggerated the incident out of all proportion. At the Cerebral Palsy Clinic, she abused the Head Start Program and claimed she was quite capable of teaching the child herself.

The diagnostic team had decided that a school experience was vital to Kathy's proper adjustment. However, they could not convince the grandmother that she should continue attending Head Start. During the summer, BUER arranged for her to enter public school kindergarten. In addition, staff supplied supplemental tutoring and counseling sessions with both Kathy and her grandmother to work out their emotional problems. By presenting educational alternatives to her grandmother, BUER elicited support necessary for more effective treatment.

Flexibility of Roles Needed for Treatment

In servicing disturbed lower-income children, BUER staff were requested to perform many tasks not generally considered the duty of psychologists, social workers, psychiatrists, and teachers. Staff helped families arrange housing, spoke to the Welfare Department about special expenses, and even helped one mother swear out a warrent for her husband's arrest. The problems of lower-income families are sometimes so diverse that ordinary tactics are not effective.

One observer took advantage of the flexibility of her role to deal with the many problems of one family. One child, Maria, was referred to BUER by the Family Service Clinic. Her older sister was a deaf mute, and she had not as yet developed any language. The observer arranged for an interview and then to transport Maria to the diagnostic nursery session. Maria had an older sister, two younger twin sisters, and a baby sister. The family was confined to their cramped, messy four room apartment and rarely ventured out. The parents spoke Spanish to one another and English to the children. None of the children seemed to have much, if any, language of their own. The oldest girl, Auria, was supposedly deaf and spoke only babbling sounds. Maria said only a few words such as, 'No, stupid,' but often imitated Auria's private language. The twins were just on the verge of language development and could only say their names.

During the interview, the observer learned that Maria was the family scapegoat. When she was one year old, her aunt moved in to live with the family. Apparently the aunt was heartily disliked by both parents. She showed a distinct preference for Maria, however, and showered her with gifts.

The aunt left the household after a series of quarrels, and Maria's mother claimed that from then on she acted spoiled and mean. Her mother remarked that Maria had temper tantrums whenever she did not get her way. During tantrums, she screamed, jumped, kicked and scratched her body all over making deep marks. Her mother claimed Maria would not mind at all and would not behave even for her father. The father refuses to stay with Maria -- though he likes the other children -- as does Maria's grandmother and other aunt. Even the neighborhood children, the mother added, would not play with Maria.

During the interview, one twin curled up in the observer's lap and dozed while the other one grabbed the interviewer's pen and scribbled on her notebook. Maria was attracted to her purse and carried it throughout the house, although she was unable to get it open. Finally, after about ten minutes of this play her mother shouted at her harshly and told her to give it back. She was then with Auria in the hall. She cried and threw a small tantrum. In the meantime, Auria grabbed the purse and headed for the kitchen. Auria was allowed to carry the purse, then unheeded by her mother, while Maria continued to cry, having both lost the purse and been scolded by her mother. This same procedure was repeated with an ashtray a few minutes later. Having everything taken away from her, Maria was then in a dark and aggressive mood. She approached the twin who was still happily scribbling with the pen on the observer's notebook, and grabbed the pen from her. Again, her mother called out sharply to her and made her give the pen back to the twin. She went into another crying spell and retreated, very angrily, behind the heating stove, peeking out between tears.

At the diagnostic nursery, Maria exhibited a great deal of cognitive ability and persistence in doing puzzles but was unwilling to interact with other children. She gave the impression of a very scared, tense child, with a tremendous potential for stubborness and negativism. Skillful at tasks performed alone, she was reluctant to participate in any group activity. Though she was clearly not deaf, it was impossible at that time to determine whether her language deficit was primarily due to physical or emotional factors.

Maria was placed in the special Head Start class. Meanwhile, the observer arranged for physical checkups for all the children in the family. When Maria was in class, one observer began a series of several visits to her home to help the younger children with their language development. She brought books and toys for the children and played with them showing them pictures. She insisted that the children be allowed to play with the toys and that they need not be stored out of the children's reach. Once, the observer noticed that the baby was never taken from the bassinet except for feeding. On her next visit, she brought an infant seat and encouraged the mother to use it so that the child would have a more stimulating environment. The observer spoke with the mother about her problems and discussed various ways of dealing with her children. Finally she arranged for a family conference to discuss Maria's behavior and ways of dealing with her.

After a year in the Head Start special class, Maria made some progress. Early in the year, her inhibiting fear and inconsistent behavior coupled with her poor coping ability and failure to use speech marked her as a child in need of immediate attention. By the end of the year, Maria's emotional behavior was more normal though she remained extremely shy with strangers. Moreover, she made dramatic progress in the area of language. Early in the year, her vocalizations consisted of grunts, cries or an occasional angry shout. But by the end of the year, she was talking continually, though some of her speech still had a rather indistinct quality about it due to the mixture of languages she heard at home.

The teacher recommended that she be placed in a normal Head Start class for the summer, and then return to the special class the next fall. In the special class, Maria would be under constant supervision of the diagnostic staff, and her parents would be more likely to cooperate in her treatment.

The complexity of the problems facing some of the South End preschoolers and their families suggests the inadequacy of traditional clinic-bound approaches to both studying and treating emotional disturbance. Most of the children seen had multiple problems. Situational problems sometimes were so severe as to create emotional disturbance in both parent and child. Moreover, proper treatment for these multi-problemed children was difficult to provide. However, the tactic of creating alternatives for lower-income individuals was often successful in getting treatment started.

IV. The Question

The always question -- are institutions going to mold or be molded by their constituents? When does it best serve the interests of children to fit? And when should institutions adapt to characteristics, needs, problems and sturctures of their clients? Everyone -- Piaget and Toynbee, to name a few -- knows that both of these processes -- adaption and accomodation -- have to take place continually. The organization changes a little, which affects the environment, which . . . But the dilemma of history is the absence of a past-present problem. The differences between the past and present is not at all like the difference between the 18th and 19th centuries -- the past and the paster. This is just as true for individuals, agencies and schools, as it is for history. It is not enough to know that the process will take place -- the institutions will change individuals will change institutions . . . We have to be with *it* when *it* occurs. And this can never be unless we can affect *its* occurrence. If we can delay or substitute for the rising or setting sun we have beaten the cycle. There is considerable physical control -- an amoral development. But what can be said about controls that affect intellect and emotions? What does "being with *it*" mean then? The decision to fit, or not, depends on an outcome and surely fitting does not necessarily (or even probably) lead to further fitting. That is, the pattern of fitting or being fitted to what takes place in home or school will not be directly related to the process that takes place after a child leaves home or school.

We talk about clinics and schools becoming responsive to lower income communities, (and we believe it). Responsiveness is more important than any particular kinds of services, professionals or strategies. Responsiveness has its own value, its own mystique which seems to fit some form of liberal, democratic, egalitarian, humanistic, non-violent world view. Do we accept responsiveness by an act of faith or must it be argued? Should our criteria be used to judge responsiveness or to determine the best road to a destination that has already been selected?

As we have reviewed our case material, some of which has been presented above, it becomes clear that alternative goals for children that we worked with in our Clinic were often neither clear nor attractive. We talked about getting children into public school classes where we would not, under any conditions, have sent our own children. There were families that had such a daily menu of disorganization and violence that our efforts to deal with the disturbance of a child were both tragic and ironic -- the child's disturbed reaction was the only healthy coping behavior in sight. For children in the South End, goals had to include housing, health, schools, playgrounds and families -- community problems towered over individual pathologies. So into the breach goes responsiveness -- maximun feasible participation of the poor. If you cannot give people housing, schools and adequate health services, you can at least allow them to administer their own poverty.

We were in the South End to provide mental health and special educational services. We were also committed to "responsiveness" -- as much as, and as comprehensive as possible. But we began to realize that they did not go together. A clinic was set up and did operate and serve children and families. We spoke to people in the community, listened to them, and took leads whenever and wherever possible. But if we were really serious about either service or responsiveness, we would have had to, more or less, abandon the other. There is too much going on between punishment and crime, form and content, means and ends. We cannot view symptoms as being independent of who has them and what is and can be done about them. If one breaks a leg, he is treated in much the same way no matter how it was broken, who the person is, in what kind of community he lives or who is doing the treating. Although much is said about the patient's desire to get well being related to the cure of physical, as well as psychological ailments, there is certainly far wider latitude about how the patient feels regarding the former than the latter. To push this simplistic argument, our work in the South End leads us to the position that the how's, who's, where's and why's are not only functionally related to disturbance, they must be considered to be it. Consequently, to study disturbance (or disorganization) without including setting and agents as necessary sources of independent variation, is to deny the problem that is poverty and to focus on irrelevancy. It makes no sense to isolate individuals or types of behavior when they do not have functional independence. The important research question is to find out about optimal units for functional independence -- what constellations of behavior, individuals, locations and groups should be studied for action -- linked explanations, in order to get optimal connectiveness, but without getting bogged down by cross-sections of behavior, groups and individuals that become prohibitive to study.

This is the first response to the question: Constellations will differ across settings -- we cannot continue to pretend to meaningfully study behavior that has important organizational correlates, independently of the settings in which they exist. They will result in what can euphemistically be referred to as spontaneous variation. But primary attention to settings emphasizes the necessary relationship between content -- what is to be observed -- and form -- how observation is to be done. Perhaps, it will not be so easy to get away with using the survey-aspirin for every research headache. Once the concept of settings is accepted as the foundation for certain kinds of studies, including disturbances in lower income communities, it will be unlikely that surveys will continue to cut across qualitatively distinct and different settings. One of the methodological aims of the discovery, creation, description and explanation of settings is to make it possible to select settings that are comparable, thus allowing for survey and quasi-experimental design.

It was towards this end that we went into the South End. What characteristics of a setting make a difference for children and their families? What is to be described, and how, when and for what audience? Is it the problem that we see -- emotional disturbance -- or that the community sees -- living, working, eating, educating? Perhaps you create a setting which is a vehicle for dialogue about who sees what. Then we can refer to the process as one of sensitization. People become aware of connections; they develop language that describes, judges and controls; this addition to their conceptual-linguistic attitude is incorporated into their thinking and feeling. Somewhere in the process the professionals and the community come to share an experience so that data take on a common meaning. The science of behavior has a new participating audience -- people asking questions, obtaining, recording, and reordering data, interpreting, explaning and, maybe, even predicting.

What then are the RESULTS of spending three years and working with children and families in the South End? What is exportable to the eager outside world -- the methods, techniques, procedures? Or what parameters can be set up for tables, textbooks and planning task forces?

Not only do we not have these kinds of results, but we feel that they should not even be entertained as questions. Research communicates by its process as well as by its results. The former will effect research staff, subjects, communities and observers of the process by their direct and immediate involvement. Disregarding results -- final reports, monographs, journal articles, written case studies, films, statistical tables -- there will always be a series of effects which can be painful, pleasant, rewarding or boring. They can be considered to have been necessary and sufficient reasons for the research, completely irrelevant, or somewhere in between. Wherever results are equivocal, unconvincing, contradictory, or trivial, the process effects are all that is left.

Our research in the South End had a strong process component from its inception -- the community people, parents, children, teachers, research assistants (many residents of the South End) and other professionals were deeply involved. This involvement was, clearly, one of the important payoffs of our work. Five hundred children and adults were directly involved with our collaborative intervention for openness, which included the development of the Clinic. Recognizing the critical (and often only) value of process as a (or the) reason for research activity, BUER staff made a series of site visits to interventional research programs throughout the Northeast, and to several in other parts of the country. Explicit attention to process as a research payoff was practically non-existent. Everybody seemed to think that the necessary and sufficient reasons for their research were publishable results and that if there were to be a payoff because of the process it would be clearly incidental and, in most cases, accidental. Our position was the reverse -- research was to be wedded with the program so that ensuing process provided experience, data and a continuing dialogue for participants. Maybe this is a small audience for research, but it is certainly much larger than that for research or national evaluation reports that do not mean anything to anyone -- just a pile of regression effects, perhaps.

However, our ideas about results are not confined to exportable techniques and epidemiological data -- there is something to communicate which, while it may seem "soft," comes closer to getting at the essence of science than any tables of data or description of independent variables. Every research report communicates an attitude -- about behavior, method, measurement, application, continuity -- that has to be the enduring and connecting goal. It is an attitude that will direct an audience to questions and methodology. It will be vital to bridging the gap between values and objective detachment. For this report we have not been troubled by an excess of intermediary data -- much of which would certainly be meaningless, but some of which might have given the reader a closer feeling and understanding of the children, families and community with which we worked. But there were real and impelling reasons why much of our data is sketchy. The high value which we gave to process, combined with the substance of the problem under study, and the emerging militancy of the community, dictated policies and priorities which were not conducive to careful and systematic collection of data, whether they be case studies, process reports, survey questionnaires or interviews. For reasons which have been discussed above, our staff consisted of many individuals, with minimal formal education, who had lived, or were currently living, in the target community. They were simply not literate enough to make any real contribution to formal data collection, other than the tests, scales and questionnaires which were part of the national evaluation package.

Again, because of our relationship with the community, we were not completely free to collect data on anything, at anytime, by anybody. There were many steps to the process, which involved members of the community and served to promote openness, but which seriously inhibited the process of data collection. Putting it in another way, there is a lot of material that is staying in the South End -- although we did not originally realize it in these terms, that became part of the deal -- and that is a crucial aspect of the attitude.

We are reasonably certain that a research operation that placed high value on data collection could not have lasted in the South End. Furthermore, there has most assuredly been a rather categorical bias in the selection of research and evaluation settings which have prevented selection of militant communities, development of provocative programming, or both. Very few Head Start Evaluation and Research centers had any difficulty obtaining parent permission to test children for several crucial reasons. They obviously were not working in militant community programs -- the most militant would not have let them in, the least would have caused all sorts of problems. We wonder about much of the reported research on Head Start -- does it all suffer from this monumental distortion?

A second factor concerns how parents are asked to sign permission slips for testing, diagnosis and/or special intervention. In most interventions opposing points of view are not deliberately presented to parents in the larger community. Parents are approached individually with permission slips rather than meeting in groups where objections can be aired before all parents. The way the question is asked, where, with who else present, all can make a huge difference both in whether or not the slip will be signed but also, and more critically, in whether there is an open dialogue about testing, psychiatry, education and children. There cannot possibly have been any two-way dialogue if all or most of the parents signed the permission slips. To extend this, the successful accomplishment of a carefully planned research design in connection with Head Start or compensatory education, is testimony to the selection of a passive community and, at the same time, a statement about a quality of intervention that is strongly confounded with that design.

All of the evaluation and research activity that is centered in the South End was pushing towards community involvement, which meant provoking militancy, not for its own sake but because it was connected with the basic goal of intervention -- the development of two-way dialogue. This was evidenced in staff composition, open meetings in the community, parent workshops and the involvement of consultants who represented militant points of view. This meant that BUER staff was constantly involved in conflict with administrators of the Head Start program, local school officials, parents' groups, other researchers and various community leaders who figured we were out to exploit the community. The generation of this conflict became the raw material of the intervention and a real basis for dealing with disturbance. We often met disturbances within the staff; severe conflicts about whether we needed to present a common front to the community and about values and priorities. We were always in the midst of the same poverty whirlpool that we were observing in the Clinic. This report responds by directing attention toward how a setting evolved and the emerging ideas that accompanied that development -- and away from the purported substance of this research -- emotionally disturbed children and their families. Within the evolution of the Clinic there was continual change about our conceptions of who we were and what we were doing. The process produced an attitude which did much to direct activities and decisions. We have here communicated a mapping of that attitude.

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